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.
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CHAPTER 1
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[Prior to 7/1/83, Social Services [770] Ch 1]
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MISSION STATEMENT

The Iowa department of human services is a public expression of Iowa's desire for a stronger community. Working cooperatively with others, the department of human services meets the unique needs of individuals who are experiencing personal, economic, social, or health problems. The primary responsibilities of the department are to help and empower individuals and families to become increasingly self-sufficient and productive, and strive to improve the well-being of all the people of the state of Iowa.

441—1.1(17A) Director. All operations of the department of human services are, by law, the responsibility of the director. The director's responsibilities include:

1.1(1) The formulation of department policy within the limits set forth in the statutes of the state of Iowa;

1.1(2) Establishing standards of performance for all divisions and offices of the department;

1.1(3) Maintaining liaison with the governor, other agencies of the state, and public and private agencies outside of state government on behalf of the department;

1.1(4) Fully informing the public of department programs;

1.1(5) Serving as principal agent for the department in all legal matters and development of legislative programs to support and improve agency efforts.

This rule is intended to implement Iowa Code section 17A.3(1)*"a."*

441—1.2(17A) Council. The director of the department has, by statute, the advice and counsel of the council on human services. This seven-member council is appointed by the governor with consent of two-thirds of the Senate and its powers and duties are policymaking and advisory with respect to the services and programs operated by the department.

1.2(1) A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

1.2(2) Where a quorum is present, a position is carried by a majority of the qualified members of the council.

1.2(3) Copies of administrative rules and other materials considered are made a part of the minutes by reference.

1.2(4) Copies of the minutes are kept on file in the director's office.

1.2(5) Tentative approval of departmental actions may be given by telephone when approval is needed prior to a formal meeting. A memorandum shall be kept of the approval and formal action taken at the next scheduled meeting.

1.2(6) At each meeting the council shall set the date and location of the next meeting.

a. The communications media shall be notified at least one week in advance of the meeting.

b. When it is necessary to hold an emergency meeting, the communications media shall be notified as far in advance of the meeting as time allows. The nature of the emergency shall be stated in the minutes.

1.2(7) In cases not covered by these rules, Robert's Rules of Order shall govern.

1.2(8) The department of inspections and appeals shall be the authorized representative to conduct hearings and appeals for the council on human services.

This rule is intended to implement Iowa Code section 17A.3(1)*"a."*

441—1.3(17A) Organization at state level. The director oversees all service and administrative functions of the department including continuous quality improvement. The deputy director for administration, the deputy director for policy, the deputy director for operations, and the office of communications report directly to the director.

1.3(1) *Deputy director for administration.* The deputy director for administration manages the general support functions of all divisions of the department. Principal responsibilities include development of program and operational budgets, accounting and administrative control of appropriation expenditures, design and development of data processing systems, and monitoring and processing of provider payments.

The administrators of the divisions of data management, fiscal management, support services, and organization development and support report directly to the deputy director for administration.

a. The administrator of the division of data management is responsible for the development and operation of the automated systems that collect and process information to generate client and vendor payments, track cases and caseloads, monitor and control agency business applications, and assess social programs. Additionally, the administrator is responsible for providing a wide range of technical support for the state institutions, personal computing assistance, office automation support, program and operational research and analysis, forecasting of program expenditures, and utilization and report development and preparation.

b. The administrator of the division of fiscal management is responsible for developing annual budgets to be presented to the council on human services, governor's office, and legislature; for monitoring expenditures; for providing management with monthly forecasts for all department budget units and subunits; and for filing quarterly federal expenditures and estimate of expenditure reports. Additionally, the administrator is responsible for providing the accounting for the department's programs and operations; for coordinating payment and contracting for purchased services; for processing claims, invoices, and payroll checks; and for operating the cost allocation system which enables recovery of federal dollars.

c. The administrator of the division of support services has responsibility for equipment, purchasing, space allocation, printing, food stamp issuance and accountability, supplies management, cash receipts, manual distribution, fixed assets inventory control, central information delivery system (CIDS) teleconferencing and the mail. Additionally, the administrator is responsible for providing administration of surplus food distribution programs, nutrition consulting services, state vehicle fleet management, and liaison with the department of general services in the development of capital improvements and major maintenance projects for department institutions.

d. The administrator of the division of organization development and support has responsibility for providing leadership, direction, and oversight of organization staff development (learning resource team) and employee services (human resource team) including labor relations, compensation, recruitment, health and safety, disaster assistance, volunteer programs, professional library services, and diversity, affirmative action, and equal opportunity programs for employees, vendors, and department clients.

1.3(2) *Deputy director for policy.* The deputy director for policy manages the development of the financial, medical and social services programs for eligible Iowans.

The administrators of the divisions of adult, children and family services, economic assistance, medical services, mental health and developmental disabilities, and policy and rule integration report directly to the deputy director for policy.

a. The administrator of the division of adult, children and family services is responsible for the development and direction of service, regulatory, and financial reimbursement programs for children, families and dependent adults, including programs for foster care, adoption, child protection, family services, day care, and child and adult abuse registries. Additionally, the administrator is responsible for setting program policy for the following institutions:

(1) The state training school in Eldora.

(2) The Iowa juvenile home in Toledo.

b. The administrator of the division of economic assistance is responsible for the development and direction of financial assistance programs, including the family investment program, the food stamp program, emergency assistance, PROMISE JOBS, entrepreneurial training, refugee cash assistance, the family development and self-sufficiency demonstration program, systematic alien verification for entitlements, diversion programs, individual development accounts, and the food stamp employment and training program.

c. The administrator of the division of medical services is responsible for the development and direction of medical service programs, including Medicaid, state supplementary assistance, refugee medical assistance, the child health insurance program (HAWK-I), and interim assistance reimbursement.

d. The administrator of the division of mental health and developmental disabilities is responsible for the development and direction of supports and services as well as the financing of such services for persons with mental illness, mental retardation, and developmental disabilities. Additionally, the administrator is responsible for setting program policy for the following institutions and programs:

(1) Cherokee Mental Health Institute.

(2) Clarinda Mental Health Institute, located on the grounds of the Clarinda Treatment Complex Institute Campus.

(3) Independence Mental Health Institute.

(4) Mount Pleasant Mental Health Institute, located on the grounds of the Mount Pleasant Treatment Center Complex.

(5) Glenwood State Hospital-School.

(6) Woodward State Hospital-School.

(7) The Civil Commitment of Sexual Offenders Unit at Oakdale.

e. The administrator of the division of policy and rule integration is responsible for providing leadership and direction agencywide for the integration of policy development and the consistency of rules, including ensuring that program policies are consistent with state and federal law and are designed to achieve programmatic goals and results; monitoring state and federal programmatic policy and financial changes; and identifying policy and rule changes to ensure alignment with program and administrative divisions to facilitate alignment with the department's mission.

1.3(3) *Deputy director for operations.* The deputy director for operations manages the delivery of the financial, medical and social services programs for eligible Iowans. The administrators of the division of child support, case management, and refugee services and the office of field support and the administrators of the five departmental regions report directly to the deputy director for operations. Additionally, the deputy director is responsible for policy implementation and day-to-day operations at the following institutions: the state training school in Eldora; the Iowa juvenile home in Toledo; Cherokee Mental Health Institute; Clarinda Mental Health Institute, located on the grounds of the Clarinda Treatment Complex Institute Campus; Independence Mental Health Institute; Mount Pleasant Mental Health Institute, located on the grounds of the Mount Pleasant Treatment Center Complex; Glenwood State Hospital-School; Woodward State Hospital-School; and the Civil Commitment of Sexual Offenders Unit at Oakdale.

a. The administrator of the division of child support, case management, and refugee services is responsible for primary support services to all line elements of the department in the areas of child support and foster care collections and refugee services, and has responsibility for the department's Title XIX case management policy and budget.

b. The chief of the office of field support is responsible for the day-to-day contact with the regional offices on administrative and program operation issues and addressing client or constituent concerns.

1.3(4) *Office of communications.* The office of communications addresses the different facets of the department's internal and external communication needs. The office of communications is responsible for providing public information to clients, constituency groups, and the media, while also facilitating internal communications within the department.

a. The legislative liaison provides federal and state liaison services, maintains legislative relations, and reviews client and constituent concerns.

b. The internal communications consultant addresses the different facets of the department's internal communication needs.

c. The public information officer is responsible for the department's external communication to the media and other outside stakeholders.

441—1.4(17A) Field operations structure.

1.4(1) *Delivery system.* The department's community service delivery system is based on service areas with offices in each county that are strategically located for purposes of client accessibility. Each service area is headed by a service area manager who is responsible for the following within the service area: effective management of the delivery of social services within the area, management of the department offices, directing all personnel, implementation of departmental policies and procedures, support for the development of social service resources within the community, and resolution of service delivery complaints. The services delivered in a service area include income maintenance and social service programs, child protection and other specialized services.

1.4(2) *Local offices.* There shall be at least one local office in each county. These local offices may be full-time or less than full-time. Full-time offices will provide income maintenance and social service program delivery and will serve as a base for the less than full-time office staff. Additional services offered in local offices may include child protection and other specialized services. Less than full-time offices will be operated on a reduced number of days per week based on county need and will provide income maintenance and social services.

This rule is intended to implement Iowa Code section 17A.3(1)*"a."*

441—1.5 Rescinded, effective October 1, 1987.

441—1.6(17A) Mental health and developmental disabilities commission. The administrator of the division of mental health and developmental disabilities has, by statute, the advice and counsel of the mental health and mental retardation commission. This 15-member commission is appointed by the governor with confirmation by two-thirds of the members of the senate. The commission's powers and duties are policymaking and advisory with respect to mental health and mental retardation, services, and programs administered by the division of mental health and developmental disabilities.

1.6(1) A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

1.6(2) Where a quorum is present, a position is carried by a majority of the qualified members of the commission.

1.6(3) Copies of administrative rules and other materials considered are made a part of the minutes by reference.

1.6(4) Copies of the minutes are kept on file in the office of the administrator of the division of mental health and developmental disabilities.

1.6(5) At each meeting the commission shall determine the next meeting date. Special meetings may be called by the chair or at the request of the majority of commission members.

1.6(6) Any person wishing to make a presentation at a commission meeting shall notify the Administrator, Division of Mental Health and Developmental Disabilities, Hoover State Office Building, Des Moines, Iowa 50319-0114, (515)281-5874, at least 15 days prior to the commission meeting.

1.6(7) In cases not covered by these rules, Robert's Rules of Order shall govern.

1.6(8) The department of inspections and appeals shall be the authorized representative to conduct hearings and appeals for the mental health and mental retardation commission.

This rule is intended to implement Iowa Code section 17A.3.

441—1.7(17A) Governor's developmental disabilities council (governor's DD council). Pursuant to the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), 42 U.S. Code, Section 6000 et seq., each state shall establish a state planning council to serve as an advocate for people with developmental disabilities. The department shall act as the council's designated state agency for the purposes of receiving funds under the DD Act.

1.7(1) *Governor's DD council responsibilities.* The governor's DD council shall:

a. Develop a state plan which meets the requirements of the DD Act.

b. Prepare and approve a budget to fund all activities and to hire staff and obtain services necessary to carry out its functions under the DD Act.

c. Hire after conferring with the director, supervise, and evaluate an executive director who shall hire and supervise council staff.

d. Prepare, submit and maintain all records and reports required by the Secretary of Health and Human Services.

1.7(2) *Governor's DD council membership.* The governor's DD council shall consist of up to 26 members appointed by the governor.

a. The principal state agencies, including, at a minimum, the departments of education, human services, and elder affairs, higher education training facilities, the university affiliated program, Iowa Protection and Advocacy Services, Inc., local agencies and nongovernmental agencies and private, nonprofit groups concerned with services to people with developmental disabilities in the state, shall be represented.

b. Consumers. At least one-half of the membership of the governor's DD council shall consist of people with developmental disabilities or their parents or guardians, or immediate relatives or guardians of people with mentally impairing developmental disabilities, and who are not employees of a state agency which receives funds or provides services under the provisions for state planning councils under the DD Act, who are not managing employees of any other entity which receives funds or provides services under the provisions for state planning councils under the DD Act, and who do not have an ownership or control interest with respect to such an entity.

(1) At least one-third of the consumer representatives shall be people with developmental disabilities.

(2) At least one-third of the consumer representatives shall be immediate relatives or guardians of people with mentally impairing developmental disabilities.

(3) At least one person shall be an immediate relative or guardian of an institutionalized or previously institutionalized person with a developmental disability.

1.7(3) *Governor's DD council terms.* Members shall be appointed for three-year terms.

a. Appointments shall be staggered so that at least one-third of the members are appointed each year.

b. Governor's DD council members shall be appointed for a maximum of two consecutive, full terms. Members who have been reappointed for more than two consecutive terms on July 1, 1993, may complete the full term of their last appointment.

c. Governor's DD council members are not eligible to receive a per diem during their term. They shall receive reimbursement for expenses, including individual and family supports necessary for participation, subject to the limitations set for state boards and commissions.

1.7(4) *Governor's DD council action.*

a. A quorum shall consist of two-thirds of the members eligible to vote.

b. Where a quorum is present, a position is carried by a majority of the members eligible to vote.

c. The use of proxies shall not be allowed.

d. Any council member representing the council before any legislative committee, public body, governmental agency or media representative shall support the council's mission, guiding principles, goals, objectives and strategies approved by the council in its state plan and other policy positions adopted by the council.

1.7(5) *Governor's DD council minutes.* Copies of the minutes are kept on file in the office of the Governor's DD Council, 617 E. Second Street, Des Moines, Iowa 50309.

1.7(6) *Governor's DD council meetings.* The governor's DD council will meet at least four times a year. Dates will be determined by the governor's DD council. Special meetings may be called by the chair or upon the written request of a majority of governor's DD council members.

a. Any person wishing to make a presentation at a governor's DD council meeting shall submit a request to the executive director of the governor's DD council. The request shall be considered by the governor's DD council chair in setting the next meeting agenda.

b. The governor's DD council shall coordinate activities with the mental health and mental retardation commission in accordance with Iowa Code chapter 225C.

1.7(7) *Attendance.*

a. A member shall be considered to have submitted a resignation when absent for three consecutive, regular governor's DD council meetings or a total of more than one-half of all regular governor's DD council meetings during a calendar year in accordance with Iowa Code section 69.15.

b. The governor's office shall be immediately notified by the governor's DD council executive director of a resignation under this subrule.

1.7(8) *Organization.* No later than October 1 of each year, the governor's DD council shall organize by electing a chair, vice-chair, and executive committee.

a. The executive committee shall consist of the governor's DD council chair, vice-chair and three members at large, one of whom shall be the immediate past chair if a current member of the governor's DD council.

b. The executive committee may exercise the power of the governor's DD council between regular governor's DD council meetings but may not override a decision of the governor's DD council.

c. The governor's DD council has the authority to create other standing and special committees and task forces as deemed necessary and to create terms of office for officers, committees, and committee chairs.

(1) The members and chairs of standing and special committees shall be appointed by the chairperson from the governor's DD council's membership. Appointments shall be approved by the governor's DD council.

(2) Noncouncil members may serve as voting members of committees if approved by the governor's DD council and shall be subject to terms as determined by the governor's DD council.

(3) Committees may act based on a simple majority of those present.

(4) Committees may create temporary task forces to assist them in their work.

1.7(9) *Procedure.* In cases not covered by this rule, Robert's Rules of Order shall govern.

This rule is intended to implement Iowa Code sections 217.6 and 225C.3.

441—1.8(17A,217) Waivers of administrative rules (hereinafter referred to as exceptions to policy). Exceptions to the department's rules may be granted in individual cases upon the director's own initiative or upon request. No exception will be granted to a rule required by state statute or by federal statute or regulation. Any exception granted must be consistent with state and federal law.

1.8(1) *Procedures for requests.*

a. Requests for exceptions must be submitted in writing to the Appeals Section, Department of Human Services, 1305 E. Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114.

b. A request for an exception is independent from a departmental appeal under 441—Chapter 7. However, a request for an exception may be combined with an appeal of a proposed decision to the director under 441—Chapter 7. A request for an exception made prior to an appeal under 441—Chapter 7 may be denied pending an appeal where factual matters need to be developed.

c. A party requesting an exception must establish that the exception is appropriate. A request for an exception should include the following information where applicable and known to the requester:

(1) The name, address, and case number or state identification number of the person or entity for whom an exception is being requested and the person requesting the exception, if different from the person for whom an exception is being requested.

(2) The specific rule to which an exception is requested or the substance thereof.

(3) The specific exception requested.

(4) Facts relevant to the factors listed in subrule 1.8(2).

(5) A history of the department's action on the case.

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

(7) The name, address, and telephone number of any person inside or outside the department with knowledge of the matter with respect to which the exception is requested.

(8) Releases of information authorizing persons with knowledge regarding the request to furnish the department information pertaining to the request.

d. Requests for exceptions shall be acknowledged within seven days. The department may give notice of the request to other affected parties. The department may also request additional information from the applicant.

e. The department shall issue a written decision on the request for an exception to policy within 120 days of receipt, unless the applicant agrees to a later date. If a request for an exception to policy has been filed in a contested case proceeding, the department may pend the request until after a final decision is issued.

f. A denial of a request for an exception is absolutely final and is not appealable under 441—Chapter 7.

g. A request for an exception does not delay the time to request an appeal under 441—Chapter 7 or for filing a petition for judicial review of a final decision in a contested case under Iowa Code section 17A.19.

h. A request for an exception is not required to exhaust administrative remedies before judicial review of department action under Iowa Code section 17A.19.

i. The department shall maintain a deidentified record of exceptions granted and denied indexed by rule available for public inspection.

1.8(2) *Policy.*

a. The director may grant an exception if the director finds, based on clear and convincing evidence, that:

(1) Failure to grant the exception will result in undue hardship;

(2) The exception will not substantially affect another person in an adverse manner;

(3) The exception is not prohibited by state or federal law; and

(4) The exception will not endanger public health, safety, or welfare.

b. The decision on whether an exception should be granted will be made at the complete discretion of the director after consideration of all relevant factors including, but not limited to, those in paragraph *"a"* and the following:

(1) The need of the person or entity directly affected by the exception. Exceptions will be granted only in cases of extreme need.

(2) Whether there are exceptional circumstances justifying an exception to the general rule applicable in otherwise similar circumstances.

(3) Whether granting the exception would result in net savings to the state or promote efficiency in the administration of programs or service delivery. Net savings or efficiency will make an exception more likely.

(4) In the case of services, assistance, or grants, whether other possible sources have been exhausted. Exceptions will not generally be granted if other sources are available.

(5) The cost of the exception to the state and the availability of funds in the department's budget.

This rule is intended to implement Iowa Code section 217.6 and 2000 Iowa Acts, House File 2206.

441—1.9(17A) Commission on children, youth and families. Rescinded IAB 10/7/98, effective 12/1/98.

441—1.10(17A,514I) HAWK-I board. The director of the department has, by statute, the advice and counsel of the HAWK-I board on the healthy and well kids in Iowa program. This seven-member board consists of the commissioner of insurance or the commissioner's designee, the director of the department of education or the director's designee, the director of the department of public health or the director's designee, and four public members appointed by the governor, subject to confirmation by two-thirds of the members of the senate. The board shall also include two members of the senate and two members of the house of representatives, serving as ex officio members.

1.10(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson of the board.

b. Members appointed by the governor and the legislative members shall serve two-year terms.

1.10(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of all aspects of the healthy and well kids in Iowa program which is administered by the division of financial, health and work supports. In carrying out these duties, the board shall do all of the following:

a. Adopt rules of the department.

b. Develop criteria for and approve all contracts.

c. Establish a clinical advisory committee.

d. Establish an advisory committee on children with special health care needs.

e. Conduct studies and evaluations and provide reports as directed by legislation.

f. Define regions of the state for which plans are offered.

g. Solicit input from the public about the program.

h. Improve interaction between the program and other public and private programs which provide services to eligible children.

i. Receive and accept grants, loans, or other advances of funds from any person and may receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purpose of the program.

1.10(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, a position is carried by a majority of the qualified members of the board.

1.10(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division of financial, health and work supports.

1.10(5) *Board meetings.*

a. The board shall meet at regular intervals at least six times each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members, but no more than twelve times per year.

b. Any person wishing to make a presentation at a board meeting shall notify the Administrator, Division of Financial, Health and Work Supports, Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50309-0114, telephone (515)281-6080, at least 15 days before the board meeting.

1.10(6) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

This rule is intended to implement Iowa Code sections 17A.3(1)*"a"* and 514I.5.

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CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES EMPLOYEES AND PROPERTY

PREAMBLE

In certain circumstances the department of human services has determined it to be permissible to enter into contracts with service providers (contractors) for the use of department employees in a service program or the use of buildings and grounds of state institutions. These rules describe the conditions and processes under which these contractual arrangements will operate and will ensure uniform procedures on all campuses regarding the contracting out of department employees and leasing of state campus buildings and grounds. These rules do not supersede existing policies regarding the sharing of department employees with other state agencies under the authority of the Iowa department of personnel. The department shall implement procedures consistently.

441—2.1(23A,225C) Definitions.

"Contract manager" is the person identified within the department of human services, division of administration, who will act as the central point of contact regarding all use and leasing of state institution buildings and grounds.

"Contractor" means a nonprofit entity as defined by Iowa Code chapter 504A that purchases the services of the department, including department employees, to be used to supplement its own service provision.

"Department" means the Iowa department of human services.

"Division" includes the divisions of mental health and developmental disabilities; and adult, children and family services.

"Lessee" means a nonprofit provider of services or other approved activity or other nonprofit entity as defined by Iowa Code chapter 504A that has been permitted to lease space in certain buildings or grounds on one or more of the mental health institutes, state hospital schools, the Iowa Juvenile Home at Toledo, Iowa, or the State Training School at Eldora, Iowa, from the department.

"State institutions" (also referred to as campuses), for the purposes of this chapter, include: the Glenwood and Woodward state hospital-schools; the Cherokee, Clarinda, Independence, and Mt. Pleasant mental health institutions; the Iowa Juvenile Home in Toledo; and the State Training School in Eldora.

"Superintendents" are the administrators of these state institutions as defined by Iowa Code chapter 218 as well as those administrators appointed by the director of the department of human services pursuant to Iowa Code chapters 233A and 233B at the Iowa Juvenile Home in Toledo and the State Training School in Eldora.

441—2.2(23A,225C) Contracts for use of the services of department employees. All determinations regarding whether the department shall enter into a contract for services shall be made by the director of the department or designee. All determinations are considered final and binding and are not subject to appeal. The director of the department or designee shall weigh the following criteria in making the decision.

2.2(1) *Expertise.* Department employees shall possess certain expertise and skills needed by a contractor.

2.2(2) *Mutual benefit.* There shall be a mutual benefit to the department and the contractor.

2.2(3) *Payment.* Payment for the full cost, both direct and indirect, of department employees shall be received from the contractor.

2.2(4) *Supplementation of services.* The intent of the department is to permit its employees to provide services to on-campus lessees. Department employees may supplement the direct service provided by the contractor, but department employees shall not assume full responsibility for the care and treatment of consumers of services of the contractor.

2.2(5) *Use of department employees.* Department employees shall not be used to fill vacancies of full-time staff positions of the contractor, nor can the full time of a single department employee be contracted to a single contractor. For time-limited periods, and when it is in the best interest of the state, a state institution, with approval of the director of the department and the director of the Iowa department of personnel, may contract to provide department employees to a contractor on a full-time basis.

2.2(6) *Nonprofit status.* Department employees shall only be contracted out to nonprofit entities as defined by Iowa Code chapter 504A.

2.2(7) *Conflict of interest.* A contract shall not be entered into if it creates a conflict of interest as defined by Iowa and federal law for either the department employees, the department in general, the state of Iowa, or the contractor.

2.2(8) *Services to department clients.* Department employees' time shall be made available to a potential contractor only if it can be done without harm to the department's institution clients who are receiving services on an inpatient or outpatient basis.

2.2(9) *Subcontracting.* The department shall not subcontract out the time or services of a person under contract to the department. Persons who perform services as independent contractors to the state of Iowa, pursuant to a personal services contract, shall not be included in any agreement entered into pursuant to this chapter. However, this does not prohibit an independent contractor from directly entering into a contractual relationship with a contractor.

441—2.3(23A,225C) Contract provisions. A contract for service entered into pursuant to this chapter shall include the following provisions, plus other provisions as determined by the director of the department or designee:

2.3(1) *Rate setting.* All contract rates will be set by the department. The contract shall cover the full costs of the department including, but not limited to, any base salary or wage, vacation, applicable leave, and other fringe benefits paid for by the state of Iowa at the time of the contract and any subsequent increases.

2.3(2) *Collective bargaining agreements.* If the department employees to be included in the contract are covered by a collective bargaining agreement, the contractor shall be bound by the applicable collective bargaining agreement. The contractor shall further agree that any decision relative to the collective bargaining agreement between the department and its employees shall be binding on the contractor. Should any provision of the agreement between the parties be found to violate the terms and conditions of an applicable collective bargaining agreement, the provision or condition contained in the agreement entered into pursuant to this chapter shall be void.

2.3(3) *Conditions of employment.* The contract shall not impose any conditions of employment outside of those conditions of employment currently imposed by the state of Iowa.

2.3(4) *Liability.* The contractor agrees to defend, indemnify, and hold harmless the state and the department against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of any services performed pursuant to an agreement entered into under this chapter.

2.3(5) *Private contracting.* A department employee covered by an agreement entered into pursuant to this chapter shall be prohibited from contracting privately with the same contractor.

2.3(6) *Conditions.* All contracts must comply with conditions and negotiations mutually agreed upon by the department and the Iowa department of personnel.

2.3(7) *Term of contract.* Contracts shall be for a specific term and shall be cosigned by the department and the Iowa department of personnel on behalf of the state of Iowa and by the contractor.

2.3(8) *Copies of contract.* Copies of the contract shall be maintained by the respective division, the business office of the respective campus, and the contractor.

2.3(9) *Program name.* Without the prior written approval of the director, the entity seeking to contract with the state shall not use or cause to be used a name for the program or project that is in any way similar to the name or part of the name of the institution.

441—2.4(23A,225C) Leasing of space at state institutions. All determinations regarding leasing space at state institutions shall be made by the director of the department or designee. All determinations are

considered final and binding and are not appealable. The director of the department or designee shall weigh the following criteria in making the determination.

2.4(1) *Available space.* Space shall be available on one or more of the campuses.

2.4(2) *Activities.* Lessees may not engage in activities that will interfere with, impede, or conflict with the basic treatment, habilitation, or care programs operated on the campuses by the department. Lessees may not engage in activities that will endanger or otherwise threaten the safety and well-being of department consumers of services, the community at large, or department employees.

2.4(3) *Nonprofit status.* Lessees must be public or private nonprofit entities as defined by Iowa Code chapter 504A and must provide documentation of nonprofit status upon request of the department.

2.4(4) *Needs and priorities.* Needs of the residents of Iowa shall be considered before needs of the residents of other states. Needs shall be prioritized as follows:

a. Needs of the department other than current occupancy and use.

b. Needs of other state or local governmental bodies for human or social service related purposes that benefit Iowans before citizens of other states.

c. Needs of other state or local governmental bodies for other than human or social service related purposes.

d. Needs of private, nonprofit entities for human or social service related purposes.

e. Needs of private, nonprofit entities for other than human or social service related purposes that are determined to be compatible uses of state institution buildings and grounds.

2.4(5) *Services.* Lessees must use the leased premises to provide disability services or other services normally delivered by the lessee.

441—2.5(23A,225C) Requirements prior to leasing. The following shall be required prior to the leasing of campus buildings or grounds.

2.5(1) *Referral to contract manager.* A campus superintendent may show available space to a potential lessee but has no authority to approve any leasing arrangements or to commit buildings or grounds to potential lessees. Superintendents shall notify the contract manager if contacted by a potential lessee. If space is available or expected to be available on the campus, the superintendent shall direct all entities interested in pursuing lease arrangements to write the contract manager in the department's central office.

2.5(2) *Written proposal.* The potential lessee shall submit a written program proposal to the contract manager that contains, at a minimum, the following information:

a. A brief history and description of the business operations of the potential lessee, including documentation of nonprofit status if needed.

b. Details regarding the proposed usage of the leased space or grounds.

c. If the proposal is to lease space for office use, the information submitted shall include the type of business to be conducted in the leased space, the proposed number of employees to be housed in the space, the expected hours of operation, and the numbers and types of persons expected to use the office for business purposes.

d. If the proposal is to provide either residential or nonresidential treatment, habilitation, care or educational services in the leased space, the information submitted shall include a detailed program description specifying the age, numbers and types of persons to be served, the habilitation or treatment modalities to be used, including the guidelines for admission to service, and the anticipated referral sources (e.g., other institutions, courts, persons from Iowa or other states).

e. If the proposal is to provide either residential or nonresidential treatment, habilitation, care or educational services, written documentation of all applicable approvals, certifications, accreditations, or licenses that authorize the potential lessee to provide the proposed service shall be submitted. Failure to obtain or maintain legally required approvals, certifications, accreditations, or licenses shall prevent the development of or cause the termination of lease agreements. Temporary leasing arrangements may be considered if deemed necessary in order for the lessee to receive the needed documentation per the above.

f. A description of the potential lessees' service and support expectations of the department such as whether department employees will be needed to assist the program and what arrangements the lessee intends to make for services such as janitorial, laundry, and food services.

g. Identification of proposed renovations that will be needed in order for the lessee to carry out its proposed activities. The lessee shall propose how and by whom the renovations would be completed. The lessee shall be responsible for the full cost involved in all renovations, and all renovations must comply with applicable federal, state, and local requirements including, but not limited to, the Americans With Disabilities Act, and health, safety, and fire codes.

h. Verification of terms and conditions that allow the department to have a cost-neutral lease (rent must cover expenses).

i. Other information deemed necessary by the contract manager.

2.5(3) *Evaluation of proposals.* The contract manager, in collaboration with the respective division administrator and the respective superintendents, shall evaluate all proposals to determine if they meet the general principles identified above. The contract manager shall recommend whether to proceed with the leasing process to the director or designee. The contract manager shall notify the potential lessee in writing of the director's or designee's decision and, if applicable, identify the reasons for denial. All decisions are considered final and binding and are not subject to appeal.

2.5(4) *Indemnity and insurance.* All contracts shall include clauses that address the following:

a. All contractors shall indemnify, hold harmless and defend the state, the department, and its officers and employees from and against all suits, actions, or claims for personal injury or death, or damage to property because of any act, omission or neglect of the contractor, its officers, agents or employees in the provision of services or other activities as provided for by administrative rule and contracts developed pursuant to this chapter, including, but not limited to:

(1) Personal injury, death or property damage of a client receiving care or services, or while on a premises owned, leased or operated by the contractor, or while being transported by the provider, either directly or by arrangement.

(2) Personal injury, death or property damage of another caused by a client while receiving care or services from the contractor.

This provision does not create any right or cause of action in the public or a third party to bring a claim or suit under or pursuant to its terms.

b. The contractor agrees that it shall have in force and effect a liability insurance policy covering all its operations in providing the care and services required by the administrative rules and by contract, including the indemnity provision above. A "Certificate of Insurance" identifying the insurance company, the policy period, the type of policy and the limits of coverage shall be filed with the department. The insurance policy and the certificate of insurance shall show the state of Iowa and the department of human services as additional named insured. The contractor further agrees that anyone transporting, or authorized to transport, clients in privately owned vehicles shall have liability insurance in force and effect covering any claim which may arise from this transport.

2.5(5) *Request for proposal.* When only one party is expressing interest in leasing space, the department, before entering into a lease agreement, shall review the proposal and determine whether the proposal and use of the space requires the department to publish a request for proposal in lieu of executing a lease between the parties. If it is determined that publishing a request for proposal is needed, the proposed lessee can then respond to the request for proposal.

2.5(6) *Program name.* Without the prior written approval of the director, the entity seeking to contract with the state shall not use or cause to be used a name for the program or project that is in any way similar to the name or part of the name of the institution.

These rules are intended to implement Iowa Code sections 23A.2 and 225C.13.

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CHAPTER 3
DEPARTMENT PROCEDURE FOR RULE MAKING

[Ch 3, 1973 IDR, renumbered as [770] Ch 77]
[Prior to 7/1/83, Social Services[770] Ch 3]
[Prior to 2/11/87, Human Services[498]]

441—3.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules adopted by the department are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

441—3.2(17A) Advice on possible rules before notice of proposed rule adoption. In addition to seeking information by other methods, the department may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1)*"a,"* solicit comments from the public on a subject matter of possible rule making by the department by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

441—3.3(17A) Public rule-making docket.

3.3(1) *Docket maintained.* The department shall maintain a current public rule-making docket.

3.3(2) *Anticipated rule making.* Rescinded IAB 3/6/02, effective 5/1/02.

3.3(3) *Pending rule-making proceedings.* The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced, by publication in the Iowa Administrative Bulletin of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1)*"a,"* to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the rule's becoming effective. For each rule-making proceeding, the docket shall indicate:

a. The subject matter of the proposed rule.

b. A citation to all published notices relating to the proceeding.

c. Where written submissions on the proposed rule may be inspected.

d. The time during which written submissions may be made.

e. The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected, and where and when oral presentations may be made.

f. Whether a written request for the issuance of a regulatory analysis or a concise statement of reasons has been filed, whether such an analysis or statement or a fiscal impact statement has been issued, and where any such written request, analysis, or statement may be inspected.

g. The current status of the proposed rule and any department determinations with respect thereto.

h. Any known timetable for department decisions or other action in the proceeding.

i. The date of the rule's adoption.

j. The date of the rule's filing, indexing, and publication.

k. The date on which the rule will become effective.

l. Where the rule-making record may be inspected.

441—3.4(17A) Notice of proposed rule making.

3.4(1) *Contents.* At least 35 days before the adoption of a rule the department shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

a. A brief explanation of the purpose of the proposed rule.

b. The specific legal authority for the proposed rule.

c. Except to the extent impracticable, the text of the proposed rule.

d. Where, when, and how persons may present their views on the proposed rule.

e. Where, when, and how persons may demand an oral proceeding on the proposed rule if the notice does not already provide for one.

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

3.4(2) *Copies of notices by mail.* Persons desiring to receive copies of future Notices of Intended Action by subscription shall complete Form 470-2250, Notice Subscription, which is available from the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114, indicating the name and address to which the notices shall be sent. Persons may subscribe to all notices of the department, or only to notices pertaining to the service, income maintenance, or medical programs. Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the department shall mail a copy of the notice to subscribers who have completed Form 470-2250 and paid the subscription price. The subscription price includes the cost of labor and supplies for copying and mailing of the notices. At the end of each calendar year, subscribers will be sent Form 470-2250 to complete if they wish to continue on the mailing list.

3.4(3) *Subscription to Web site.* Persons desiring to receive a weekly memo via E-mail listing new rules under proposal by the department shall go to the department's Web site at http://www.dhs.state.ia.us/policyanalysis/ to subscribe or E-mail the department's rules administrator at policyanalysis@dhs.state.ia.us indicating the E-mail address to which the memo shall be sent. This service shall be available without charge.

441—3.5(17A) Public participation.

3.5(1) *Written comments.* For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data, and views, in writing or via electronic transmission, on the proposed rule. These submissions should identify the proposed rule to which they relate and should be submitted to the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114, or to the department's rules administrator at policyanalysis@dhs.state.ia.us.

3.5(2) *Oral proceedings.* The department may, at any time, schedule an oral proceeding on a proposed rule. The department shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the department by the administrative rules review committee, a governmental subdivision, a state agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following additional information:

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

The department may waive technical compliance with these procedures.

Oral proceedings scheduled by the department regarding rules directly affecting indigent clients shall be held in each of the service areas defined in rule 441—1.4(17A).

In the case of rules not directly affecting indigent clients, the department shall determine for each rule for which oral proceedings are scheduled whether it will be necessary to hold presentations in all eight locations. Anyone may object to the department's decision prior to the date of the proceedings by writing the same addressee specified in the Notice of Intended Action for receiving written data, views, or arguments. The department shall review the adequacy of the number of locations in light of the comments received.

3.5(3) *Conduct of oral proceedings.*

a. Applicability. This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)*"b"* or subrule 3.5(2).

b. Scheduling and notice. An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

c. Presiding officer. An employee of the department shall preside at the oral proceeding on the proposed rules and shall present a prepared statement on the substance of the rules. The presiding officer shall transcribe the proceeding or prepare a written summary of the presentations made.

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

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

(2) Whenever possible, persons making oral presentations should submit their testimony in writing.

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

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

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

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

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

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

3.5(4) *Additional information.* In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the department may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

The department may send notices of proposed rule making and a request for comments to any agency, organization, or association known to it to have a direct interest or expertise pertaining to the substance of the proposed rule.

3.5(5) *Accessibility.* The department shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the office of policy analysis at (515)281-8440 in advance to arrange access or other needed services.

441—3.6(17A) Regulatory analysis.

3.6(1) *Definition of small business.* A "small business" is defined in Iowa Code section 17A.4A(7).

3.6(2) *Distribution list.* Small businesses or organizations of small businesses may be registered on the department's small business impact list by making a written application addressed to the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114. The application for registration shall state:

a. The name of the small business or organization of small businesses;

b. Its address;

c. The name of a person authorized to transact business for the applicant;

d. A description of the applicant's business or organization. An organization representing 25 or more persons who qualify as a small business shall indicate that fact.

e. Whether the registrant desires copies of Notices of Intended Action at cost or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

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

3.6(3) *Time of distribution.* Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the department shall mail to all registered small businesses or organizations of small businesses, in accordance with their request, either a copy of the Notice of Intended Action or notice of the subject of that proposed rule making. In the case of a rule that may have an impact on small business adopted in reliance upon Iowa Code section 17A.4(2), the department shall mail notice of the adopted rule to registered businesses or organizations prior to the time the adopted rule is published in the Iowa Administrative Bulletin.

3.6(4) *Qualified requestors for regulatory analysis—economic impact.* The department shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2)*"a"* after a proper request from:

a. The administrative rules coordinator.

b. The administrative rules review committee.

3.6(5) *Qualified requestors for regulatory analysis—business impact.* The department shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2)*"b"* after a proper request from:

a. The administrative rules review committee.

b. The administrative rules coordinator.

c. At least 25 or more persons who sign the request provided that each represents a different small business.

d. An organization representing at least 25 small businesses. That organization shall list the name, address and telephone number of not less than 25 small businesses it represents.

3.6(6) *Time period for analysis.* Upon receipt of a timely request for a regulatory analysis, the agency shall adhere to the time lines described in Iowa Code section 17A.4A(4).

3.6(7) *Contents of request.* A request for a regulatory analysis is made when it is mailed or delivered to the department. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A(1).

3.6(8) *Contents of concise summary.* The contents of the concise summary shall conform to the requirements of Iowa Code sections 17A.4A(4) and (5).

3.6(9) *Publication of a concise summary.* The department shall make available to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A(5).

3.6(10) *Regulatory analysis contents—rules review committee or rules coordinator.* When a regulatory analysis is issued in response to a written request from the administrative rules review committee or the administrative rules coordinator, the regulatory analysis shall conform to the

requirements of Iowa Code section 17A.4A(2)*"a,"* unless a written request expressly waives one or more of the items listed therein.

3.6(11) *Regulatory analysis contents—substantial impact on small business.* When a regulatory analysis is issued in response to a written request from the administrative rules review committee, the administrative rules coordinator, at least 25 persons signing that request who each qualify as a small business or by an organization representing at least 25 small businesses, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2)*"b."*

441—3.7(17A,25B) Fiscal impact statement. A rule that mandates additional combined expenditures exceeding $100,000 by all affected political subdivisions, or agencies and entities which contract with political subdivisions to provide services must be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement must satisfy the requirements of Iowa Code section 25B.6.

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

441—3.8(17A) Time and manner of rule adoption.

3.8(1) *Time of adoption.* The department shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the department shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

3.8(2) *Consideration of public comment.* Before the adoption of a rule, the department shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any written summary of the oral submissions and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

3.8(3) *Reliance on department expertise.* Except as otherwise provided by law, the department may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

441—3.9(17A) Variance between adopted rule and published notice of proposed rule adoption.

3.9(1) *Allowable variances.* The department shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

a. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and

b. The differences are a logical outgrowth of the contents of that Notice of Intended Action or the comments submitted in response thereto; and

c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

3.9(2) *Fair warning.* In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question the department shall consider the following factors:

a. The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests.

b. The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action.

c. The extent to which the effects of the rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

3.9(3) *Petition for rule making.* The department shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action upon which the rule is based, unless the

department finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee, within three days of its issuance.

3.9(4) *Concurrent rule-making proceedings.* Nothing in this rule disturbs the discretion of the department to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

441—3.10(17A) Exemptions from public rule-making procedures.

3.10(1) *Omission of notice and comment.* To the extent the department for good cause finds that public notice and participation are unnecessary, impracticable, or contrary to the public interest in the process of adopting a particular rule, the department may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The department shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

3.10(2) *Categories exempt.* The following narrowly tailored category of rules is exempted from the usual public notice and participation requirements because those requirements are unnecessary, impracticable, or contrary to the public interest with respect to each and every member of the defined class: rules mandated by state or federal law, including federal statutes or regulations establishing conditions for federal funding of departmental programs under Titles IV, XIX, XX, or XXI to the Social Security Act, or under the federal Food Stamp Act, where the department is not exercising any options under federal law.

3.10(3) *Public proceedings on rules adopted without them.* The department may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule it adopts in reliance upon subrule 3.10(1). Upon written petition by a governmental subdivision, the administrative rules review committee, a state agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, the department shall commence a standard rule-making proceeding for any rule specified in the petition that was adopted in reliance upon subrule 3.10(1). This petition must be filed within one year of the publication of the specified rule in the Iowa Administrative Bulletin as an adopted rule. The rule-making proceeding on that rule must be commenced within 60 days of the receipt of the petition. After a standard rule-making proceeding commenced pursuant to this subrule, the department may either readopt the rule it adopted without benefit of all usual procedures on the basis of subrule 3.10(1) or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

441—3.11(17A) Concise statement of reasons.

3.11(1) *General.* When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the department shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114. The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests shall be considered made on the date received.

3.11(2) *Contents.* The concise statement of reasons shall contain:

a. The reasons for adopting the rule;

b. An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any change;

c. The principal reasons urged in the rule-making proceeding for and against the rule, and the department's reasons for overruling the arguments made against the rule.

3.11(3) *Time of issuance.* After a proper request, the department shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request.

441—3.12(17A) Contents, style, and form of rule.

3.12(1) *Contents.* Each rule adopted by the department shall contain the text of the rule and, in addition:

a. The date the department adopted the rule;

b. A brief explanation of the principal reasons for the rule-making action if the reasons are required by Iowa Code section 17A.4(1)*"b,"* or the department in its discretion decides to include the reasons;

c. A reference to all rules repealed, amended, or suspended by the rule;

d. A reference to the specific statutory or other authority authorizing adoption of the rule;

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

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

g. The effective date of the rule.

3.12(2) *References to materials not published in full.* When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the department shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules and of significant issues involved in these rules. The summary statement shall also describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter and any matter incorporated by reference, may be obtained from the department. The department shall provide a copy of that full text at actual cost upon request and shall make copies of the full text available for review either electronically or at the State Law Library.

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

3.12(3) *Style and form.* In preparing its rules, the department shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

441—3.13(17A) Department rule-making record.

3.13(1) *Requirement.* The department shall maintain an official rule-making record for each rule it proposes by publication in the Iowa Administrative Bulletin of a Notice of Intended Action, or adopts. The rule-making record and materials incorporated by reference shall be available for public inspection.

3.13(2) *Contents.* The department rule-making record shall contain:

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

b. Copies of Form 470-0096, Rule Log, containing dates of actions and Iowa Administrative Bulletin references relating to the rule or the proceeding upon which the rule is based;

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

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

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

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

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

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

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

j. A copy of any significant written criticism of the rule, including a summary of any requests for an exception to policy for the rule; and

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

3.13(3) *Effect of record.* Except as otherwise required by a provision of law, the department rule-making record required by this rule need not constitute the exclusive basis for department action on that rule.

3.13(4) *Maintenance of record.* The department shall maintain the rule-making record for a period of not less than five years from the later of the date the rule to which it pertains became effective or the date of the Notice of Intended Action.

441—3.14(17A) Filing of rules. The department shall file each rule it adopts in the office of the administrative rules coordinator. The filing shall be executed as soon after adoption of the rule as is practicable. At the time of filing, each rule shall have attached to it any fiscal impact statement and any concise statement of reasons that was issued with respect to that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to the filing of that rule, the note or statement must be attached to the filed rule within five working days after the fiscal impact statement or concise statement is issued. In filing a rule, the department shall use the standard form prescribed by the administrative rules coordinator.

441—3.15(17A) Effectiveness of rules prior to publication.

3.15(1) *Grounds.* The department may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The department shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

3.15(2) *Special notice.* When the department makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3), the department shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule's indexing and publication. The term "all reasonable efforts" requires the department to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the department of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any one or more of the following means: radio, newspaper, television, signs, mail, telephone, personal notice, or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of subrule 3.15(2).

441—3.16(17A) Review by department of rules.

3.16(1) *Request for review.* Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator for the department to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the department shall conduct a formal review of a specified rule to determine whether a new rule should be adopted instead or the rule should be amended or repealed. The department may refuse to conduct a review if it has conducted a review of the specified rule within five years prior to the filing of the written request.

3.16(2) *Conduct of review.* In conducting the formal review, the department shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report shall include a concise statement of the department's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any requests for exceptions to the rule received by the department or granted by the department. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the department's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report shall also be available for public inspection.

These rules are intended to implement Iowa Code chapter 17A and Iowa Code section 25B.6.

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CHAPTER 4
PETITIONS FOR RULE MAKING

[Ch 4, 1974 IDR, renumbered as [770] Ch 78]
[Prior to 7/1/83, Social Services[770] Ch 4]
[Prior to 2/11/87, Human Services[498]]

441—4.1(17A) Petition for rule making. Any person or state agency may file a petition for rule making with the department at the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114. A petition is deemed filed when it is received by that office. The department must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE DEPARTMENT OF HUMAN SERVICES

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

The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the department's authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner's arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.
6. Any request by petitioner for a meeting provided for by subrule 4.4(1).

4.1(1) The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

4.1(2) The department may deny a petition because it does not substantially conform to the required form.

441—4.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The department may request a brief from the petitioner or from any other person concerning the substance of the petition.

441—4.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to Rules Administrator, Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

441—4.4(17A) Agency consideration.

4.4(1) *Forwarding of petition and meeting.* Within five working days after the filing of a petition, the department shall submit a copy of the petition and any accompanying brief to the administrative rules coordinator and to the administrative rules review committee. Upon request by the petitioner in the petition, the department shall schedule a brief and informal meeting between the petitioner and a member of the staff of the department to discuss the petition. The department may request the petitioner to submit additional information or argument concerning the petition. The department may also solicit

comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

4.4(2) *Action on petition.* Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the department shall, in writing, deny the petition, and notify petitioner of its action and the specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed notified of the denial or grant of the petition on the date when the department mails or delivers the required notification to petitioner.

4.4(3) *Denial of petition for nonconformance with form.* Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the department's rejection of the petition.

These rules are intended to implement Iowa Code section 17A.7.

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CHAPTER 5
DECLARATORY ORDERS

[Ch 5, 1973 IDR, renumbered as [770] Ch 79]
[Prior to 7/1/83, Social Services[770] Ch 5]
[Prior to 2/11/87, Human Services[498]]

441—5.1(17A) Petition for declaratory order. Any person may file a petition with the department for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the department at the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114. A petition is deemed filed when it is received by that office. The department shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and should substantially conform to the following form:

BEFORE THE DEPARTMENT OF HUMAN SERVICES

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

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested. For public assistance policy rulings, the request should state facts such as the amount of income and resources of a person who may be affected by the policy.
2. A citation and the relevant language of the specific statutes, rules, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers. A request which seeks to change rather than to declare or determine policy will be denied.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by the petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by the petitioner for a meeting provided for by rule 441—5.7(17A).
9. The petitioner's state identification number, if applicable.

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

441—5.2(17A) Notice of petition. Within five working days of receipt of a petition for a declaratory order, the department shall give notice of the petition to all persons not served by the petitioner pursuant to rule 441—5.6(17A) to whom notice is required by any provision of law.

441—5.3(17A) Intervention.

5.3(1) *Nondiscretionary intervention.* Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 15 working days of the filing of a petition for declaratory order and before the 30-day time for department action under rule 441—5.8(17A) shall be allowed to intervene in a proceeding for a declaratory order.

5.3(2) *Discretionary intervention.* Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the department.

5.3(3) *Filing and form of petition for intervention.* A petition for intervention shall be filed at the office of policy analysis. A petition is deemed filed when it is received by that office. The department shall provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and should substantially conform to the following form:

BEFORE THE DEPARTMENT OF HUMAN SERVICES

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

The petition for intervention must provide the following information:

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

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

441—5.4(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The department may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

441—5.5(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the Rules Administrator, Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

441—5.6(17A) Service and filing of petitions and other papers.

5.6(1) *Service.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served by mailing or personal delivery upon each of the parties of record to the proceeding, and on all other persons identified as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons. All documents filed shall indicate all parties or other persons served and the date and method of service.

5.6(2) *Filing.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114. All documents are considered filed upon receipt.

441—5.7(17A) Consideration. Upon request by the petitioner, the department shall schedule a brief and informal meeting between the original petitioner, all intervenors, and a member of the staff of the department, to discuss the questions raised. The department may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the department by any person.

441—5.8(17A) Action on petition.

5.8(1) *Time frames for action.* Within 30 days after receipt of a petition for a declaratory order, the director or the director's designee shall take action on the petition as required by Iowa Code section 17A.9(5).

5.8(2) *Date of issuance of order.* The date of issuance of an order or of a refusal to issue an order is the date of mailing of the order or refusal or date of delivery if service is by other means unless another date is specified in the order.

441—5.9(17A) Refusal to issue order.

5.9(1) *Reasons for refusal to issue order.* The department shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department to issue an order.
3. The department does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other department or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a department decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
10. The petitioner requests the department to determine whether a statute is unconstitutional on its face.

5.9(2) *Action on refusal.* A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final department action on the petition.

5.9(3) *Filing of new petition.* Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the department's refusal to issue a ruling.

441—5.10(17A) Contents of declaratory order—effective date. In addition to the ruling itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

441—5.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

441—5.12(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the department, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final agency action on the petition.

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

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CHAPTER 6
Reserved
[Ch 6, 1973 IDR, renumbered as [770] Ch 80]

CHAPTER 7
APPEALS AND HEARINGS

[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]
[Prior to 7/1/83, Social Services[770] Ch 7]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7.
[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

"Administrative hearing" means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

"Administrative law judge" means an employee of the department of inspections and appeals who conducts appeal hearings.

"Agency" means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

"Aggrieved person" means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. For financial assistance (including the family investment program, refugee cash assistance, child care assistance, emergency or disaster assistance, family or community self-sufficiency grants, family investment program hardship exemptions, and state supplementary assistance dependent person, in-home health related care, and residential care facility benefits), a person:

- Whose request to be given an application was denied.
- Whose application for assistance has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of assistance.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

2. For food assistance, a person:

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of benefits.
- Whose request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

3. For medical assistance, healthy and well kids in Iowa, IowaCare, family planning services, and waiver services, a person (see numbered paragraph "7" for providers):

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Whose eligibility has been terminated, suspended or reduced.
- Who has been notified that there will be a reduction in the level of benefits or services the person is eligible to receive.

- Who has received a determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing.
- Who has been notified that the level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
- Who has been notified that level of care requirements have not been met.
- Who has been aggrieved by a failure to take into account the appellant's choice in assignment to a coverage group.
- Who contests the effective date of assistance or services.
- Who contests the amount or effective date of health insurance premium payments, healthy and well kids in Iowa premium payments, Medicaid for employed people with disabilities premium payments, IowaCare premium payments, or the spenddown amount under the medically needy program.
- Who contests the amount of client participation.
- Whose claim for payment or prior authorization has been denied.
- Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.
- Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by medical assistance.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.
- Who has been denied requested nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) and has exhausted the grievance procedures established by the broker pursuant to 441—subrule 78.13(7).

4. For social services, including, but not limited to, adoption, foster care, and family-centered services, a person (see numbered paragraph "7" for providers):

- Whose request to be given an application was denied.
- Whose application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.
- For whom it is determined that the person must participate in a service program.
- Whose claim for payment of services has been denied.
- Who has been notified that a protective or vendor payment will be established.
- Who has been notified that there will be a reduction or cancellation of services.
- Who has been notified that an overpayment of services has been established and repayment is requested.
- Who applies for an adoption subsidy after the adoption has been finalized.
- Who alleges that the adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.
- Who has not been referred to community care as provided in rule 441—186.2(234).
- Who has been referred to community care as provided in rule 441—186.2(234) and has exhausted the community care provider's dispute resolution process.
- Who has been referred to aftercare services under 441—Chapter 187 and has exhausted the aftercare provider's dispute resolution process.

5. For child support recovery, a person:

- Who is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or whose dispute based on the date of collection has not been acted on in a timely manner.
- Who is contesting a claim or offset as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.
- Whose name has been certified for passport sanction as provided in Iowa Code section 252B.5.

- Who has been notified that there will be a termination in services as provided in rule 441—95.14(252B).

6. For PROMISE JOBS, a person:

- Whose claim for participation allowances has been denied, reduced, or canceled.
- Who claims that the contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- Who is dissatisfied with the results of informal grievance resolution procedures, or who fails or refuses to receive informal grievance resolution procedures.
- Who has been notified that PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.
- Who alleges acts of discrimination on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.
- Who claims displacement by a PROMISE JOBS participant.

7. For providers, a person or entity:

- Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.
- Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.
- Whose contract as a Medicaid patient manager has been terminated.
- Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).
- Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.
- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.
- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).
- Who, as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member, has a dispute regarding payment of claims.

8. For the child or dependent adult abuse registry, juvenile sex offender registry or criminal record check evaluation, a person:

- Who is a person alleged responsible for child abuse.
- Who has requested correction of dependent adult abuse information.
- Who has been restricted from or denied employment in a health care facility, state institution, or other facility based on a record check. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facilities" include, but are not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
- Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.

9. For mental health and developmental disabilities, a person:

- Whose application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.
- Who has been notified that there will be a reduction or cancellation of services under the state payment program.

10. For HIPAA (Health Insurance Portability and Accountability Act) decisions, a current or former applicant or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

- To restrict use or disclosure of protected health information was denied.
- To change how protected health information is provided was denied.
- For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1)*"i,"* persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- To amend protected health information was denied.
- For an accounting of disclosures was denied.

11. For drug manufacturers, a manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement.

12. Bidders that have participated in a competitive procurement bid process. Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

13. Individuals and providers that are not listed in paragraphs "1" to "12" may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

"Appeal" denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

"Appeals advisory committee" means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

"Appeals section" means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

"Appellant" denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

"Attribution appeal" means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

"Authorized representative" means a person or organization designated by an appellant to act on the appellant's behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

"Bidder" means an individual or entity that submits a proposal in response to a competitive procurement issued by the department.

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

"Department" means the Iowa department of human services.

"Department of inspections and appeals" means the state agency that contracts with the department to conduct appeal hearings.

"Director" means the director of the department of human services or the director's designee.

"Due process" denotes the right of a person affected by an agency decision to receive a notice of decision or notice of action and an opportunity to be heard at an appeal hearing and to present an effective defense.

"Electronic account" means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

"Electronic case record" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

"Ex parte communication" means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

"Exchange" means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

"Food assistance administrative disqualification hearing" means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

"Group hearings" denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

"Informal conference" means a type of meeting between the appellant and the appellant's representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant's action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

"In person or face-to-face hearing" means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

"Intentional program violation" means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

"Local office" means the county, institution or district office of the department of human services.

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

"Prehearing conference" means a type of meeting between the appellant and the appellant's representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

"Presiding officer" means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department's director or the director's designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

"Presumption" denotes an inference as to the existence of a fact not known or drawn from facts that are known.

"PROMISE JOBS discrimination complaint" means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant's representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

"PROMISE JOBS displacement grievance" means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives that alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

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

"Reconsideration" means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME) or its subcontractors,
2. The managed health care review committee,
3. A division or bureau within the department,
4. The mental health and disability services commission,
5. A licensed health care professional as specified in 441—paragraph 9.9(1)*"i,"* or
6. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision will be issued with appeal rights.

"Sent" means deposited in the mail with first-class postage or posted to an individual's electronic account.

"Teleconference hearing" means an appeal hearing conducted by an administrative law judge over the telephone.

"Timely notice period" is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, "timely notice period" shall be at least five calendar days from the date a notice is sent.

"Vendor" means a provider of health care under the medical assistance program or a provider of services under a service program.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 9254B**, IAB 12/1/10, effective 1/1/11; **ARC 0304C**, IAB 9/5/12, effective 11/1/12; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 0583C**, IAB 2/6/13, effective 4/1/13; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1206C**, IAB 12/11/13, effective 1/15/14; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.2(17A) Application of rules. Rescinded IAB 7/29/09, effective 9/2/09.

DIVISION I

441—7.3(17A) Presiding officer. Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

441—7.4(17A) Notification of hearing procedures. Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

7.4(1) Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

a. To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.

b. To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

7.4(2) The department shall inform individuals of the availability of the services and how to access such services.

[**ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.5(17A) The right to appeal. Any person or group of persons may file an appeal with the department concerning any issue. The department shall determine whether a hearing shall be granted.

7.5(1) *When a hearing is granted.* A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law or Constitution, except as limited in subrules 7.5(2) and 7.5(4).

7.5(2) *When a hearing is not granted.* A hearing shall not be granted when:

a. One of the following issues is appealed:

(1) The service is no longer available through the department.

(2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.

(3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.

(4) Children have been removed from or placed in a specific foster care setting.

(5) Children have not been placed with or have been removed from a preadoptive family.

(6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).

(7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.

(8) Notice has been issued from the treasury offset program for a food assistance overpayment.

(9) A rate determination has been reviewed under rule 441—152.3(234).

(10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).

(11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).

(12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph "5" of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

(13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).

(14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.

(15) A final decision from a previous hearing with a presiding officer has been implemented.

(16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.

(17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.

(18) An MCO provider or Iowa plan contractor fails to submit a document providing the member's approval of the request for appeal.

(19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.

(20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.

b. Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.

c. State or federal law or regulation provides for a different forum for appeals.

d. The appeal is filed prematurely as:

(1) There is no adverse action by the department, or

(2) The appellant has not exhausted the reconsideration process.

e. Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).

f. The sole basis for denying, terminating or limiting assistance under 441—Chapter 47 or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.

g. The appellant is an "aggrieved party" as defined in rule 441—22.1(225C) and is eligible for a compliance hearing with the mental health and developmental disabilities commission in accordance with rule 441—22.5(225C).

h. The issue appealed is moot.

i. The issue appealed has previously been determined in another appeal by the same appellant.

7.5(3) *Group hearings.* The department may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.5(4) *Time limit for granting hearing to an appeal.* Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

a. *General standards.* In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

b. *Food assistance, Medicaid or healthy and well kids in Iowa standard.* For appeals regarding food assistance, Medicaid or the healthy and well kids in Iowa program, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. *Offset standards.* For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441—paragraph 14.4(1)*"e."* When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

d. *Abuse standard.*

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing within 10 calendar days after the appeal notification.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

e. *Displacement and discrimination standard.* PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4)*"a"*(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4)*"a"* in relation to the action alleged to have involved discrimination.

f. *Risk assessment standard.* An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

7.5(5) *Informal settlements.* The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

7.5(6) *Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

1. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance;
2. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance;
3. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance;
4. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance; or
5. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph *"a."*

c. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) *Appeals of Medicaid, state supplementary assistance (SSA), and HAWK-I program overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

(1) Form 470-2891, Notice of Medical Assistance Overpayment; or

(2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph *"a."*

7.5(8) *Appeal rights under the family investment program limited benefit plan.* A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues

the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

7.5(9) *Appeals of child care assistance benefit overissuances or overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

7.5(10) *Appeals of food assistance overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on:

(1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;

(2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or

(3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.

b. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10; **ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 0304C**, IAB 9/5/12, effective 11/1/12; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 0583C**, IAB 2/6/13, effective 4/1/13; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.6(17A) Informing persons of their rights.

7.6(1) *Written and oral notification.* The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance:

(1) The right to request a hearing.

(2) The procedure for requesting a hearing.

(3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

(4) Provisions, if any, for payment of legal fees by the department.

b. Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

c. Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

d. Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

7.6(2) *Authorized representation or responsible party.* Persons may be represented for purposes of this chapter by an authorized representative or an individual or organization recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

a. The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

b. An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

c. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must sign an agreement that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

d. An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

e. The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

f. The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

g. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted online via the department's Web site, by mail, by electronic mail, by facsimile transmission or in person.

h. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

i. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.

7.7(1) *Notification.*

a. Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

d. "Timely" means that the notice is sent at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is sent.

e. "Adequate" means a written notice that includes:

(1) A statement of what action is being taken,

(2) The effective date of such action,

(3) A clear statement of the specific reasons supporting the intended action,

(4) The manual chapter number and subheading supporting the action and the corresponding rule reference,

(5) An explanation of the appellant's right to appeal, and

(6) The circumstances under which assistance is continued when an appeal is filed.

7.7(2) *Dispensing with timely notice.* Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

c. The recipient has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.

f. The agency establishes that the recipient has been accepted for assistance in another state.

g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the recipient's physician.

i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS), Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)*"b"*or rule 441—75.52(249A).

l. The agency terminates benefits for failure to return a completed report form, as described in paragraph *"k."*

m. The agency approves or denies an application for assistance.

n. The agency implements a mass change based on law or rule changes that affect a group of recipients.

7.7(3) *Action due to probable fraud.* When the agency obtains facts indicating that assistance should be canceled, suspended, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the action shall be timely when sent at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

7.7(4) *Conference during the timely notice period.* Rescinded IAB 7/10/13, effective 9/1/13.

7.7(5) *Notification not required.* Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

e. When services of the community self-sufficiency grant project are available to all PROMISE JOBS participants as specified in 441—subrule 47.46(1).

7.7(6) *Reinstatement.*

a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234). FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.8(17A) Opportunity for hearing.

7.8(1) *Initiating an appeal.* To initiate an appeal, a person, the person's authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. All appeals shall be made in writing, except for food assistance, Medicaid and healthy and well kids in Iowa appeals, which may be made by telephone or in person.

b. A written request may be submitted via the department's Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

c. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance, Medicaid and healthy and well kids in Iowa appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) *Informal conference.* When requested by the appellant, an informal conference with a representative of the department shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(4) *Prehearing conference.* When requested by the appellant or department, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

7.8(5) *Interference.* Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right of the department to deny or dismiss an appeal.* The department or the department of inspections and appeals has the right to deny or dismiss the appeal when:

a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).

b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.

c. It has been abandoned.

d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.

e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant or the appellant's authorized representative fails, without good cause, to appear at the prehearing or hearing.

7.8(7) *Denial of due process.* Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made in writing and signed by the appellant or the appellant's legal counsel.

7.8(9) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt, complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and forward that form, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) *When assistance continues.* Assistance shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked, or other proposed adverse action be taken pending a final decision on an appeal when:

a. An appeal is filed within the timely notice period.

b. The appellant requests a hearing within ten days from receipt of a notice of cancellation or reduction of food assistance, family investment program, or medical assistance benefits, based on the completed report form, including:

(1) Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS).

(2) Medicaid Review, Form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS).

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

c. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

7.9(2) *When assistance does not continue.* The adverse action appealed to suspend, reduce, restrict, or cancel assistance; revoke a license, registration, certification, approval, or accreditation; or take other proposed action may be implemented pending a final decision on appeal when:

a. An appeal is not filed within the timely notice period or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

7.9(3) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5).

When the department action is sustained, excess assistance paid pending a hearing decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.

7.9(4) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(5) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed within the timely notice period of the notice of decision or notice of action establishing the beginning date of the LBP.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

7.9(6) *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—subrule 41.25(11) shall be established when the department is affirmed in a timely appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

a. The appeal is filed within the timely notice period of the notice of decision establishing the beginning date of the ineligibility period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 1261C**, IAB 1/8/14, effective 3/1/14; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—7.10(17A) Procedural considerations.

7.10(1) *Registration.* Upon receipt of the notice of appeal, the department shall register the appeal.

7.10(2) *Acknowledgment.*

a. Upon receipt of the notice of appeal, the department shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

c. The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person's own expense.

7.10(3) *Granting a hearing.* The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at that hearing.

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the department or a hearing over the denial.

7.10(4) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in department of inspections and appeals rules 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by vendors or agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

d. In cases involving an appeal of a sex offender risk assessment, the hearing shall be held within 30 days of the date of the appeal request.

e. Emergency assistance appeals shall be expedited.

7.10(5) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) *Reschedule requests.* Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the department or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant

request for an in-person hearing made to the department shall be communicated to the department of inspections and appeals immediately.

b. All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

b. A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to the appellant at the last-known address. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.

7.13(1) *Examination of the evidence.* The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

7.13(2) *Conduct of hearing.*

a. The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

b. For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

7.13(3) *Opportunity for response.* Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

7.13(4) *Default.* If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

a. Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

b. A default decision or a proposed decision rendered on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested before the default, but the relief awarded against the defaulting party may not exceed the requested relief before the default.

c. Proceedings after a default decision are specified in subrule 7.13(5).

d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

7.13(5) *Proceedings after default decision.*

a. Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).
2. Death or serious illness in the party's immediate family.
3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
2. Confusion as to the date and time for the hearing.
3. Failure to follow the directions on the notice of hearing.
4. Oversleeping.
5. Other acts demonstrating a lack of due care by the party.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Upon a final decision granting a motion to vacate, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

7.13(6) *Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.*

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

e. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).
2. Death or serious illness in the party's immediate family.
3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
2. Confusion as to the date and time for the hearing.
3. Failure to follow the directions on the notice of hearing.
4. Oversleeping.
5. Other acts demonstrating a lack of due care by the party.

f. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

g. Upon a final decision granting a motion to vacate, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6)*"a"* or *"j."*

i. Any review on the merits by the director requested pursuant to paragraph 7.13(6)*"a"* and stayed pursuant to paragraph 7.13(6)*"b"* pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0304C**, IAB 9/5/12, effective 11/1/12; **ARC 0487C**, IAB 12/12/12, effective 2/1/13]

441—7.14(17A) Limitation of persons attending.

7.14(1) The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

7.14(2) For an appeal hearing regarding child abuse:

a. Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.

b. The department shall not be considered to be a party who can adequately represent the interests of any other subject.

c. Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.

[**ARC 0487C**, IAB 12/12/12, effective 2/1/13]

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) *Record.* The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

a. The notice of appeal.

b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) *Findings of fact.* Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

7.16(3) *Proposed decision.* Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be sent by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

7.16(4) *Appeal of the proposed decision.* After issuing a proposed decision, the administrative law judge shall submit it to the department with copies to the appeals advisory committee.

a. The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

b. When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

c. The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) *Time limit for appeal of a proposed decision.* Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) *Appeal of the proposed decision by the department.* The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

When the director grants a review of a proposed decision on the department's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) *Appeal of the proposed decision by the appellant.* When the director grants a review of a proposed decision all other parties shall be so notified.

7.16(8) *Opportunity for oral presentation of appeal of the proposed decision.* In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(9) *Time limits.*

a. A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance and vendors, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

b. Failure to reach a decision within the time frames set forth in paragraph 7.16(9)*"a"* shall not affect the merits of the appellant's appeal.

c. Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

d. For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

e. The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(10) *Final decision.* The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14]

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.

7.18(1) *Prohibited communication.* There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph *"c."*

b. Persons described in paragraph *"c"* shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term "personally investigating" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

7.18(2) *Commencement of prohibition.* Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

7.18(3) *When communication is ex parte.* Rescinded IAB 4/30/03, effective 7/1/03.

7.18(4) *Avoidance of ex parte communication.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

7.18(5) *Communications not prohibited.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

7.18(6) *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect

of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

441—7.20(17A) Right of judicial review and stays of agency action.

7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

7.20(2) *Stays of agency action.*

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

b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food assistance hearings and appeals.

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with federal regulation, Title 7, Section 273.15, as amended to January 1, 2008.

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with federal regulation, Title 7, Section 273.16, as amended to January 1, 2008.

7.21(3) *Conduct of a food assistance administrative disqualification hearing.* Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

a. The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

b. The household member or that person's representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person's representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

7.21(4) *Consolidating hearings.* Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

7.21(5) *Attendance at hearing.* The household member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

7.21(6) *Food assistance administrative disqualification hearing decisions.* The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to subrule 7.21(3), paragraph *"b,"* the 90 days for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

441—7.22(17A) FIP disqualification hearings. Rescinded IAB 4/30/03, effective 7/1/03.

441—7.23(17A) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.

e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

7.24(2) *Issuance of order.*

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

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

(1) Personal delivery.

(2) Certified mail, return receipt requested, to the last address on file with the department.

(3) Certified mail to the last address on file with the department.

(4) First-class mail to the last address on file with the department.

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

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

7.24(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.24(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

441—7.25 to **7.40** Reserved.

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process.
[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the department's decision.

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, e-mail, or in-person delivery.
[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

7.43(1) *Hearing time frame.* The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

7.43(2) *Registration.* Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) *Acknowledgment.* Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

7.43(4) *Granting a hearing.* The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to the appellant and the appellant's representative advising of the denial of the hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial may present additional information relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A).

7.43(7) *Reschedule requests.* Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.43(8) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.44(17A) Procedures for bidder appeal.

7.44(1) Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) Amendments to notice of appeal. The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

7.44(4) If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

7.44(5) The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

7.44(6) The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) Stay of agency action for bidder appeal.

7.45(1) *When a stay may be requested.*

a. Any party appealing the issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

b. Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

7.45(2) *When a stay is granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

7.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) Request for review of the proposed decision. A request for review of the proposed decision shall follow the provisions outlined in subrules 7.16(5) to 7.16(7).

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.47(17A) Other procedural considerations.

7.47(1) *Consolidation—severance.*

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

(1) The matters at issue involve common parties or common questions of fact or law;

(2) Consolidation would expedite and simplify consideration of the issues; and

(3) Consolidation would not adversely affect the rights of parties to those proceedings.

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

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

7.47(2) *Presiding officer.* Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to rule 441—7.3(17A).

7.47(3) *Rights of appellants during hearings.* All rights afforded appellants at rule 441—7.13(17A) shall apply.

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in subrule 7.16(1).

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) Petition. When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

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

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

(1) On whose behalf the petition is filed;

(2) The particular provisions of the statutes and rules involved;

(3) The relief demanded and the facts and law relied upon for relief; and

(4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

7.49(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

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

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

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

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

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications listed at 441—7.18(17A) apply.
[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review listed at 441—7.20(17A) apply.
[**ARC 1206C**, IAB 12/11/13, effective 1/15/14]

These rules are intended to implement Iowa Code chapter 17A.

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◊ Two or more ARCs

CHAPTER 8
PAYMENT OF SMALL CLAIMS

[Prior to 7/1/83, Social Services[770] Ch 8]
[Prior to 2/11/87, Human Services[498]]

441—8.1(217) Authorization to reimburse. The department is authorized to expend moneys as reimbursement for replacement or repair of personal items of the department's employees damaged or destroyed by clients of the department during the employee's tour of duty. The following requirements shall apply for filing small claims with the employee's agency:

8.1(1) Claimant shall provide the supervisor with a detailed written account of incident, and when possible include a name of a witness.

8.1(2) Written reports shall be supplemented with vendor's estimate of repair or replacement cost when practical. Replacement items shall be of similar quality or cost.

8.1(3) The supervisor shall review all reports and approve or deny the claim based on available information.

8.1(4) Claims which are approved for payment shall be paid from the support allocation of the department and shall not exceed $150 per item.

8.1(5) Vouchers submitted for payment of claims shall be supported with a vendor's invoice of claimant's receipt for expense.

This rule is intended to implement Iowa Code section 217.23.

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CHAPTER 9
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

PREAMBLE

These rules describe the records of the Iowa department of human services and procedures for access to these records. All records of the department are open to the public except those that the department is authorized or required by law to keep confidential.

These rules also implement the federal Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 CFR Parts 160 and 164 as amended to August 14, 2002. These rules set forth the standards the department of human services must meet to protect the privacy of protected health information. The department has chosen to be considered a hybrid entity for purposes of HIPAA because there are parts of the department that are not part of the covered entity for purposes of HIPAA compliance.

The rules on protected health information apply only to those parts of the department that are considered part of the covered entity: the named health plans and health care providers defined in these rules and the divisions or programs that perform functions on behalf of a named health plan. Targeted case management, refugee services, and the child support recovery unit are examples of parts of the department that are not included in the covered entity.

441—9.1(17A,22) Definitions. As used in this chapter:

"Business associate" means a person or organization, other than a member of the department's workforce, who meets one of the following criteria:

1. Performs, or assists in the performance of, a function or activity on behalf of the department which involves the use or disclosure of protected health information, including claims processing or administration, data analysis, research, utilization review, quality assurance, billing, benefit management, practice management, and repricing, or any other function or activity regulated by the rules on protected health information.

2. Provides legal, auctuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the department. The provision of the service shall involve the disclosure of protected health information from the department or from another business associate of the department to the person or organization.

"Client" means a person who has applied for or received services or assistance from the department.

"Confidential record" means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include:

1. Records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and

2. Records or information contained in records that is specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record.

Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Covered entity" means:

1. A health plan.

2. A health care clearinghouse.

3. A health care provider that transmits any health information in electronic form in connection with a transaction covered by the HIPAA regulations.

"Covered functions" means the functions performed by a covered entity which make the covered entity a health plan, health care clearinghouse, or health care provider.

"Custodian" means the department or a person who has been given authority by the department to act for the department in implementing Iowa Code chapter 22. For local offices, the custodian is the service area manager. For a child support recovery office, the custodian is the regional administrator.

For an institution, the custodian is the institution superintendent. For a central office unit, or for requests dealing with more than one service area, region, or institution, the custodian is the division administrator.

"Data aggregation" means the action by which a business associate combines protected health information of the department with protected health information of another covered entity to permit data analyses that relate to the health care operations of the respective covered entities.

"Department" means the Iowa department of human services.

"Designated record set" means a group of records maintained by or for the department that is:

1. The medical records about subjects that are maintained for facilities;
2. The enrollment, payment, and eligibility record systems maintained for Medicaid; or
3. The enrollment, payment, and eligibility record systems maintained for the HAWK-I program that are used, in whole or in part, by the HAWK-I program to make decisions about subjects.

For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for the department.

"Disclosure" means releasing, transferring, providing access to, or divulging in any other manner information outside the organization holding the information.

"Facility" or *"facilities"* means, with respect to HIPAA rules about health information, one or more of these department institutions: Cherokee Mental Health Institute, Clarinda Mental Health Institute, Glenwood Resource Center, Independence Mental Health Institute, Mount Pleasant Mental Health Institute, and Woodward Resource Center.

"Health care" means care, services, or supplies related to the health of a subject. "Health care" includes, but is not limited to, the following:

1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedures with respect to the physical or mental condition, or functional status, of a subject or affecting the structure or function of the body; and
2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

"Health care clearinghouse" means a public or private organization, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions:

1. Processes or facilitates the processing of health information received from another organization in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another organization and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving organization.

"Health care operations" has the same definition as that stated in 45 CFR 164.501 as amended to August 14, 2002. For a covered entity in the department, "health care operations" has the following meaning:

1. For Medicaid, "health care operations" means any of the following activities of the department to the extent that the activities are related to covered functions:

- Conducting quality assessments and evaluating outcomes.
- Developing clinical guidelines.
- Improving general health or reducing costs.
- Developing protocols, including case management and care coordination models for MediPASS and pharmacy case management as well as for other service areas and client populations under the Medicaid program.
- Informing clients of treatment alternatives and related functions.
- Reviewing competence or qualifications or performance of health care professionals using the surveillance and utilization review subsystem.
- Reviewing health plan performance from encounter data.
- Premium rating and rate setting.

- Performing activities in reinsurance of risk with the health maintenance organizations.
- Reviewing medical level of care and prior authorizations.
- Obtaining legal services through the attorney general's office or the county attorney's office.
- Cooperating in audits and fraud detection by Iowa and federal auditors, the Iowa Medicaid enterprise, or the department of inspections and appeals.
- Conducting business planning and development including formulary development by the drug utilization review commission and the department's research and statistics staff.
- Managing activities, which include claiming of federal financial participation, recovering unknown third-party liability, recovering nursing care funds and other expenditures through estate recovery, Grouper programming for hospitals, lock-in activities, and federal reporting of paid claims.
- Providing customer service, which includes income maintenance workers answering questions about lock-in providers, copayment for pregnant women, and claims payment problems; and the Iowa Medicaid enterprise provider services unit answering questions on claims payment.
- Coordinating care and monitoring the effective delivery of child welfare services to ensure the safety and well-being of children, including reporting and providing testimony to the court of jurisdiction on the condition and service progress of a client receiving services from the department. These care coordination and monitoring activities include providing information concerning the client to attorneys representing the various parties in the court proceedings.

2. For the HAWK-I program, "health care operations" means any of the following activities of the department to the extent that the activities are related to covered functions:

- Conducting quality assessment and improvement activities, including evaluation of outcomes and development of clinical guidelines; population-based activities relating to improving health or reducing health care costs, protocol development and related functions that do not include treatment.
- Reviewing health plan performance.
- Premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Performing business planning and development functions, such as conducting cost-management and planning-related analyses relating to management and operations and the development or improvement of methods of payment or coverage policies.
- Performing business management and general administrative activities, including, but not limited to, management activities relating to implementation of and compliance with privacy requirements, customer service, and resolution of internal grievances.

3. For the facilities, "health care operations" means any of the following activities of the department to the extent that the activities are related to covered functions:

- Conducting quality assessment and improvement activities, including evaluation of outcomes and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from these activities; population-based activities relating to improving health or reducing health care costs; protocol development; case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.
- Reviewing the competence or qualifications of health care professionals.
- Evaluating performance of practitioners, providers and health plans.
- Conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers.
- Training of non-health care professionals.
- Performing accreditation, certification, licensing, or credentialing activities.
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Performing business planning and development functions, such as conducting cost-management and planning-related analyses related to managing and operating the organization,

including formulary development and administration, development or improvement of methods of payment or coverage policies.

- Performing business management and general administrative activities, including, but not limited to, management activities related to implementation of and compliance with the requirements of HIPAA; customer service, which includes the provision of data analyses for policyholders, plan sponsors, or other customers, provided that protected health information is not disclosed to the policyholder, plan sponsor, or customer; resolution of internal grievances; and activities consistent with the applicable requirements of subrule 9.10(29) on creating de-identified health information or a limited data set.

"Health care provider" means a provider of services, as defined in Section 1861(u) of the Social Security Act and 42 U.S.C. 1395x(u); a provider of medical or health services, as defined in Section 1861(s) of the Social Security Act and 42 U.S.C. 1395x(s); and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business. In the department, "health care provider" means one of the department's facilities.

"Health information" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a subject; the provision of health care to a subject; or the past, present, or future payment for the provision of health care to a subject.

"Health maintenance organization (HMO)" means a public or private organization licensed as an HMO under the commerce department, insurance division, 191—Chapter 40.

"Health oversight agency" means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or organization acting under a grant of authority from or contract with a public agency, that is authorized by law to:

1. Oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance; or
2. Enforce civil rights laws for which health information is relevant.

The term "health oversight agency" includes the employees or agents of the public agency and its contractors or persons or organizations to which the agency has granted authority.

"Health plan" means an individual or group plan that provides or pays the cost of medical care, as defined at 45 CFR 160.103 as amended to August 14, 2002. In the department, "health plan" means Medicaid or HAWK-I.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"Law enforcement official" means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or
2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

"Legal representative" is a person recognized by law as standing in the place or representing the interests of another for one or more purposes. For example, guardians, conservators, custodians, attorneys, parents of a minor, and executors, administrators, or next of kin of a deceased person are legal representatives for certain purposes.

"Mental health information" means oral, written, or otherwise recorded information which indicates the identity of a person receiving professional services (as defined in Iowa Code section 228.1(8)) and which relates to the diagnosis, course, or treatment of the person's mental or emotional condition. Mental or emotional conditions include mental illness, mental retardation, degenerative neurological conditions and any other condition identified in professionally recognized diagnostic manuals for mental disorders.

"Open record" means a record other than a confidential record.

"Payment," with respect to HIPAA rules about protected health information, has the same definition as that stated in 45 CFR 164.501 as amended to August 14, 2002. In the department, "payment" applies to subjects for whom health care coverage is provided under the Medicaid program or the HAWK-I program. "Payment" has the following meanings for these health plans:

1. For Medicaid, "payment" includes activities undertaken by this health plan to:

- Determine or fulfill its responsibility for coverage and provision of benefits under the health plan.
- Obtain or provide reimbursement for the provision of health care.
- Determine eligibility, including spenddown for the medically needy program or obtaining premiums for the Medicaid for employed people with disabilities program, or coverage, including coordination of benefits or the determination of cost-sharing amounts, and adjudication or subrogation of health benefit claims.
- Perform risk adjustment of amounts due based on enrollee health status and demographic characteristics.
- Bill; manage claims; collect; obtain payment under a contract for reinsurance, including stop-loss insurance and excess of loss insurance; and conduct related health care data processing.
- Review health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
- Perform utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.

2. For the HAWK-I program, "payment" includes activities undertaken by this health plan to:

- Obtain reimbursement or pay for providing health care services.
- Obtain premiums or determine or fulfill its responsibility for coverage and providing benefits. Activities include, but are not limited to, determinations of eligibility for coverage, including coordination of benefits or the determination of cost-sharing amounts; billing and collection activities; review of health care services with respect to coverage under a health plan; and utilization review activities.

"Personally identifiable information" means information about or pertaining to the subject of a record which identifies the subject and which is contained in a record system. The incidental mention of another person's name in a subject's record (e.g., as employer, landlord, or reference) does not constitute personally identifiable information.

"Personal representative" means someone designated by another as standing in the other's place or representing the other's interests for one or more purposes. The term "personal representative" includes, but is not limited to, a legal representative. For disclosure of protected health information, the definition of "personal representative" is more restrictive, as described at rule 441—9.15(17A,22).

"Plan sponsor" has the same definition as that stated in Section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

"Protected health information" means information that contains a subject's medical information, including past, present, or future treatment and payment information. "Protected health information" is a composite of multiple fields that grouped together give detailed accumulative information about a subject's health. When joined together in an accessible record set, the following three distinct areas of health-care-processing file information constitute protected health information:

1. Information that identifies the subject.
2. Medical information describing condition, treatment, or health care.
3. Health care provider information.

Identification information together with any information from one of the other two categories constitutes protected health information. When the information that identifies the subject is present in the record set, any information that ties health care data to the subject's identification information constitutes protected health information.

"Psychotherapy notes" means notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the subject's medical record. "Psychotherapy notes" excludes medication prescription and monitoring, counseling session start and stop times, the methods of therapy and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

"Public health authority" means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or organization acting under a grant of authority from or contract with a public agency that is responsible for public health matters as part of its official mandate. "Public health authority" includes the employees or agents of the public agency and its contractors or persons or organizations to which it has granted authority.

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

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

"Required by law" means a mandate contained in federal law, federal regulation, state law, state administrative rule, case law, or court order that is enforceable in a court of law. For the purposes of this chapter, "required by law" includes statutes or regulations that require the production of information, such as statutes or regulations that require the information if payment is sought under a government program that provides public benefits.

"Research" means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

"Subject" means the person who is the subject of the record, whether living or deceased.

"Substance abuse information" means information which indicates the identity, diagnosis, prognosis, or treatment of any person in an alcohol or drug abuse program.

"Transaction" means the electronic transmission of information between two parties to carry out financial or administrative activities related to health care. The term includes the following defined HIPAA standard transactions:

- Health care claims or equivalent encounter information.
- Health care payment and remittance advice.
- Coordination of benefits.
- Health care claim status.
- Enrollment and disenrollment in a health plan.
- Eligibility for a health plan.
- Health plan premium payments.
- Referral certification and authorization.
- Other transactions that the Secretary of Health and Human Services may prescribe by regulation.

"Treatment," with respect to HIPAA rules about protected health information, means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation among health care providers about a patient; and the referral of a patient from one health care provider to another.

"Use," with respect to protected health information, means the sharing, application, utilization, examination, or analysis of the information within an organization that maintains the protected health information.

"Workforce" means employees, volunteers, trainees, and other people whose conduct, in the performance of work for the covered entity, is under the direct control of the covered entity, whether or not these people are paid by the covered entity.

441—9.2(17A,22) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound department determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This department is committed to the policies set forth in Iowa Code chapter 22. Department staff shall cooperate with members of the public in implementing the provisions of that chapter.

441—9.3(17A,22) Requests for access to records.

9.3(1) *Location of record.* A request for access to a record should be directed to the director or the particular department office where the record is kept.

a. If the location of the record is not known by the requester, the request shall be directed to the Office of Policy Analysis, Department of Human Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

b. If a request for access to a record is misdirected, department personnel will promptly forward the request to the appropriate person within the department.

9.3(2) *Office hours.* Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

9.3(3) *Request for access.* Requests for access to open records may be made in writing, in person, or by telephone. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

9.3(4) *Response to requests.* Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 441—9.4(17A,22) and other applicable provisions of law.

9.3(5) *Security of record.* No person may, without permission from the custodian, search or remove any record from department files. Examination and copying of department records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

9.3(6) *Copying.* A reasonable number of copies of an open record may be made in the department office. If photocopy equipment is not available in the department office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

9.3(7) *Fees.*

a. *When charged.* The department may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. *Copying and postage costs.* Price schedules for published materials and for photocopies of records supplied by the department shall be prominently posted in department offices. Copies of records may be made by or for members of the public on department photocopy machines or from electronic storage systems at cost as determined and posted in department offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

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

d. *Advance deposits.*

(1) When the estimated total fee chargeable under this subrule exceeds $25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

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

e. *Summary of health information.* The department my charge a fee for the cost of preparing an explanation or summary of health information as provided in paragraph 9.9(1)*"c."* The department and the subject requesting the information shall agree to the amount of any fee imposed before the department prepares the explanation or summary.

441—9.4(17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 441—9.3(17A,22).

9.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

9.4(2) *Requests.* The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

9.4(3) *Notice to subject of record and opportunity to obtain injunction.*

a. Except as provided in 441—subrule 175.41(2), after receiving a request for access to a confidential record and before releasing the record, the custodian may make reasonable efforts to promptly notify any person:

(1) Who is a subject of that record,

(2) Who is identified in that record, and

(3) Whose address or telephone number is contained in the record.

b. To the extent such a delay is practicable and in the public interest, the custodian may give the notified subject a reasonable time to seek an injunction under Iowa Code section 22.8. The custodian shall inform the subject identified in the record of how much time the subject has to seek an injunction before the information will be released.

9.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

a. The name and title or position of the custodian responsible for the denial; and

b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

9.4(5) *Request granted.* Except as provided in 441—subrule 175.41(2), when the custodian grants a request for access to a confidential record, the custodian shall notify the requester or the person who is to receive the information and include any limits on the examination and copying of the record.

9.4(6) *Records requiring special procedures.* Special procedures are required for access to:

a. Child abuse information. Access to child abuse information is obtained according to rules 441—175.41(235A) and 441—175.42(235A).

b. Dependent adult abuse information. Access to adult abuse information is governed by rule 441—176.10(235A).

c. Quarterly list. Rescinded IAB 10/4/00, effective 12/1/00.

441—9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

9.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

9.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian.

a. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request.

b. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit stating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts.

c. Requests to temporarily treat a record as a confidential record shall specify the precise period of time for which that treatment is requested.

d. A person filing such a request shall, if possible, provide a copy of the record in question from which those portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the department by the person requesting confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

9.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the department does not request that it be withheld from public inspection under Iowa Code sections 22.7(3) and 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

9.5(4) *Timing of decision.* A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

9.5(5) *Request granted or deferred.* If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

9.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester, the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs

the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

9.5(7) *Rights to request privacy protection for protected health information.* When the subject is requesting a restriction or confidential communication of protected health information, the department shall follow the provisions of this subrule, as applicable, in addition to the provisions of subrules 9.5(1) through 9.5(6).

a. Restriction of uses and disclosures.

(1) The subject may request that the department restrict uses or disclosures of the subject's protected health information:

1. To carry out treatment, payment, or health care operations; and

2. To persons involved in the subject's care or for notification purposes as permitted under subrule 9.7(3).

(2) The subject shall submit a request to the department on Form 470-3953, Request to Restrict Use or Disclosure of Health Information. If applicable, the subject shall provide verification that it is reasonable to anticipate the use or disclosure will endanger the subject.

(3) The department is not required to agree to a restriction. The department shall deny any restriction when the restriction would adversely affect the quality of the subject's care or services, the restriction would limit or prevent the department from making or obtaining payment for services, or federal or state law requires the use or disclosure. The department shall approve the request for restriction only when the use or disclosure would endanger the subject and none of the above reasons for denial apply.

(4) The department shall send the subject a written notice to accept or deny the restriction.

(5) If the department agrees to a restriction, it may not use or disclose protected health information in violation of the restriction. EXCEPTION: The department may use restricted protected health information or disclose the information to a health care provider when needed for the emergency treatment of the subject who requested the restriction. If restricted protected health information is disclosed to a health care provider for emergency treatment, the department shall request that the health care provider not further use or disclose the information.

(6) A restriction agreed to by the department under paragraph 9.5(7)*"a"* shall not prevent disclosures of protected health information to the Secretary of Health and Human Services to investigate or determine the department's compliance with federal HIPAA regulations. Also, a restriction shall not prevent uses or disclosures permitted or required for the categories listed in subparagraphs 9.14(5)*"a"*(1) through (11).

(7) The department may terminate its agreement to a restriction in writing if:

1. The subject agrees to or requests the termination in writing;

2. The subject orally agrees to the termination and the oral agreement is documented; or

3. The department informs the subject that it is ending its agreement to a restriction for protected health information created or received after it has so informed the subject.

b. Confidential communications. Subjects may ask to receive communications of protected health information by alternative means or at alternative locations. The department shall accommodate reasonable requests. For Medicaid and HAWK-I, the subject is required to clearly indicate the reason for requesting the confidential communication. Facilities shall not require the subject to explain the basis for the request as a condition of providing confidential communications.

(1) The subject shall request a confidential communication from the department using Form 470-3947, Request to Change How Health Information Is Provided.

(2) The department may require the subject to provide:

1. When appropriate, information as to how payment, if any, will be handled; and

2. An alternative address or other method of contact.

441—9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records.

9.6(1) *All programs.* Except as otherwise provided by law, a subject may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that subject. However, the subject is not authorized to alter the original copy of the record or to expand the official record of any department proceeding.

a. The subject shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian or to the office of policy analysis.

b. The request to review such a record or the written statement of additions, dissents, or objections must be dated and signed by the subject, and shall include the current address and telephone number of the subject or the subject's representative.

9.6(2) *Additional procedures for protected health information.*

a. *Right to amend.* A subject may request that the department amend protected health information or a record about the subject in a designated record set for as long as the protected health information is maintained in the designated record set. A subject shall submit a request to the department using Form 470-3950, Request to Amend Health Information. The subject shall provide a reason to support the requested amendment.

b. *Timely action.*

(1) The department shall act on a subject's request for an amendment no later than 60 days after receipt of the request.

(2) If the department is unable to act on the amendment within 60 days, the department may extend the due date one time, for a period not to exceed 30 days. In order to extend the due date, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department will complete its action on the request. The department shall provide this written statement within the 60-day period after receipt of the request.

c. *Action on amendment.* If the department grants the requested amendment, in whole or in part, the department shall comply with the following requirements.

(1) The department shall timely inform the subject that the amendment is accepted. The subject shall identify relevant persons with whom the amendment needs to be shared and agree to have the department share the amendment with these persons.

(2) The department shall make the appropriate amendment to the protected health information or record by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

(3) The department shall make reasonable efforts to inform and provide the amendment to:

1. Persons identified by the subject as having received protected health information about the subject and as needing the amendment; and

2. Persons, including business associates, that the department knows have the subject's protected health information and that may have relied, or could foreseeably rely, on the information to the detriment of the subject.

d. *Denial of amendment.* The department may deny a subject's request for amendment, if the department determines that the protected health information or record that is the subject of the request:

(1) Was not created by the department, unless the subject provides a reasonable basis for the department to find that the originator of the protected health information is no longer available to act on the requested amendment;

(2) Is not part of the designated record set;

(3) Would not be available for inspection under rule 441—9.9(17A,22); or

(4) Is accurate and complete.

e. *Action on denial of amendment.* If the department denies the requested amendment, in whole or in part, the department shall provide the subject with a timely, written denial.

(1) The subject may submit to the department a written statement of disagreement with the denial of all or part of a requested amendment and the basis of the disagreement, in accordance with 45 CFR

164.526 as amended to August 14, 2002. The subject shall submit the statement of disagreement by filing an appeal request under subrule 9.14(7). The appeal request constitutes the statement of disagreement.

(2) The department shall prepare a written rebuttal to the subject's statement of disagreement, in accordance with 45 CFR 164.526 as amended to August 14, 2002. The appeal decision constitutes the rebuttal statement. The department shall provide a copy of the appeal decision to the subject who submitted the appeal request.

f. Record keeping of disputed amendments. The department shall, as appropriate, identify the record or protected health information in the designated record set that is the subject of the disputed amendment. The department shall append or otherwise link the subject's request for an amendment, the department's denial of the request, and the subject's appeal and the final decision, if any, to the designated record set.

g. Future disclosures regarding disputed amendments.

(1) If an appeal has been submitted by the subject, the department shall include the material appended in accordance with paragraph 9.6(2)*"f"* or, at the election of the department, an accurate summary of the information, with any subsequent disclosure of the protected health information to which the disagreement relates.

(2) If the subject has not submitted an appeal, the department shall include the subject's request for amendment and its denial, or an accurate summary of the information, with any subsequent disclosure of the protected health information only if the subject has requested this action.

(3) When a subsequent disclosure is made using a standard transaction that does not permit the additional material to be included with the disclosure, the department may separately transmit the material required by subparagraph 9.6(2)*"g"*(1) or (2), as applicable, to the recipient of the standard transaction.

h. Actions on notices of amendment. When the department is informed by another covered entity of an amendment to a subject's protected health information, the department shall amend the protected health information in designated record sets as provided by subparagraph 9.6(2)*"c"*(2).

441—9.7(17A,22,228) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records to be disclosed, the particular person or class of persons to whom the record may be disclosed, and the time period during which the record may be disclosed. The subject of the record and, where applicable, the person to whom the record is to be disclosed may be required to provide proof of identity.

No confidential information about clients of the department shall be released without the client's consent, except as provided in rule 441—9.10(17A,22). Release of information includes:

1. Granting access to or allowing the copying of a record,
2. Providing information either in writing or orally, or
3. Acknowledging information to be true or false.

9.7(1) *Forms.*

a. General. Department staff shall use Form 470-2115, Authorization for the Department to Release Information, for releases by the subject that do not involve health information requiring use of the authorization form described in paragraph 9.7(1)*"c."*

b. Obtaining information from a third party. The department is required to obtain information to establish eligibility, determine the amount of assistance, and provide services. Requests to third parties for this information involve release of confidential identifying information about clients. Except as provided in rule 441—9.9(17A,22), the department may make these requests only when the client has authorized the release on one of the following forms.

(1) Form 470-0461, Authorization for Release of Information.
(2) Form 470-1630, Household Member Questionnaire.
(3) Form 470-1631, Bank or Credit Union Information.
(4) Form 470-4670, Addendum for Application and Review Forms for Release of Information.

(5) Form 470-1638, Request for School Verification.
(6) Form 470-2844, Employer's Statement of Earnings.
(7) Form 470-1640, Verification of Educational Financial Aid.
(8) Form 470-3742, Financial Institution Verification.
(9) Form 470-3951, Authorization to Obtain or Release Health Care Information.

c. Health information.

(1) When consent or authorization for use or disclosure of health information is required, facilities and department staff responding to third-party requests for health information shall use Form 470-3951, Authorization to Obtain or Release Health Care Information, or a form from another source that meets HIPAA requirements.

The department shall not require a subject to sign a HIPAA authorization form as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. The department as a health care provider may require a subject to sign a HIPAA authorization form for the use or disclosure of protected health information for research, as a condition of the subject's receiving research-related treatment.

A subject may revoke a HIPAA authorization provided under subparagraph 9.7(1)*"c"*(1) at any time, provided that the revocation is in writing using Form 470-3949, Request to End an Authorization, except to the extent that the department has taken action in reliance thereon.

(2) Except as provided in subparagraph 9.7(1)*"c"*(1), department staff shall release mental health or substance abuse information only with authorization on Form 470-0429, Consent to Obtain and Release Information, or a form from another source that meets requirements of law.

d. Photographs and recordings. The department uses Form 470-0060, Authorization to Take and Use Photographs, and Form 470-0064, Authorization to Take and Use Photographs of Minor or Ward, for permission to use photographs in department publications. The department shall obtain authorization from the subject or person responsible for the subject (such as a guardian, custodian, or personal representative) before taking photographs or making any type of recording for any purpose other than those specifically allowed by law or for internal use within an institution.

e. Veteran's Home. Rescinded IAB 10/29/03, effective 11/1/03.

9.7(2) *Exceptions to use of forms.*

a. Counsel. Appearance of counsel before the department on behalf of the subject of a confidential record is deemed to constitute consent for the department to disclose records about the subject to the subject's attorney.

b. Public official. A letter from the subject to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the department shall be treated as an authorization to release information. The department shall release sufficient information about the subject to the official to resolve the matter.

c. Medical emergency. Department staff may authorize release of confidential information to medical personnel in a medical emergency if the subject is unable to give or withhold consent. As soon as possible after the release of information, the subject shall be advised of the release.

d. Abuse information. Consent to release information is not required to gather information for investigations of child abuse or dependent adult abuse.

9.7(3) *Opportunity for subject to agree or object.* This subrule describes when the department may use or disclose protected health information, without a written authorization, to persons involved in the subject's care and for notification purposes. However, the department shall give the subject an opportunity to agree or object, unless this requirement is waived as specified in paragraph 9.7(3)*"e."*

a. Involvement in the subject's care. The department may disclose protected health information that is directly relevant either to a subject's care or to payment related to the subject's care, provided payment is relevant to the person's involvement in the subject's care. The person involved must be:

(1) A family member;
(2) Another relative;
(3) A close personal friend of the subject; or
(4) Any other person identified by the subject.

b. Notification purposes. The department may use or disclose protected health information to notify, or assist in notifying, identifying or locating a family member, a personal representative of the subject, or another person responsible for the care of the subject of the subject's location, general condition or death. For disaster relief purposes, the use or disclosure shall be in accordance with paragraph 9.7(3)*"f."*

c. Uses and disclosures with the subject present. If the subject is present for, or available before, a use or disclosure permitted by this subrule and has the capacity to make health care decisions, the department may use or disclose the protected health information if the department:

(1) Obtains the subject's agreement;

(2) Provides the subject with the opportunity to object to the disclosure, and the subject does not express an objection; or

(3) Reasonably infers from the circumstances, based on the exercise of professional judgment, that the subject does not object to the disclosure.

d. Informing the subject. The department may orally inform the subject of and obtain the subject's oral agreement or objection to a use or disclosure permitted by this subrule.

e. Limited uses and disclosures when the subject is not present. When the subject is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the subject's incapacity or an emergency circumstance, the department may, in the exercise of professional judgment, determine that disclosure is in the best interest of the subject.

(1) When the department determines that disclosure is in the subject's best interest, the department may disclose only the protected health information that is directly relevant to the person's involvement with the subject's health care.

(2) The department may use professional judgment and its experience with common practice to make reasonable inferences of the subject's best interest in allowing a person to act on behalf of the subject to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

f. For disaster relief purposes. The department may use protected health information or disclose protected health information to a public or private organization authorized by law or by its charter to assist in disaster relief efforts for the purpose of coordinating with these organizations the uses or disclosures permitted by paragraph 9.7(3)*"b."* The requirements in paragraphs 9.7(3)*"c"* and *"d"* apply to these uses and disclosures to the extent that the department, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

[**ARC 0420C**, IAB 10/31/12, effective 1/1/13]

441—9.8(17A,22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department shall notify the person of how the information will be used, which persons outside the department might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested.

9.8(1) This notice may be given in these rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

9.8(2) The notice shall generally be given at the first contact with the department and need not be repeated. Where appropriate, the notice may be given to a person's legal or personal representative. Notice may be withheld in an emergency or where it would compromise the purpose of a department investigation.

9.8(3) In general, the department requests information to determine eligibility and benefit levels for assistance, to provide appropriate services or treatment, and to perform regulatory and administrative functions. Information is routinely shared outside the department when required by rules or law. Consequences of failure to provide information include ineligibility for public assistance, denial of licensure or regulatory approval, or inadequate service provision.

441—9.9(17A,22) Release to subject.

9.9(1) *Access by subjects to protected health information.*

a. Right of access. Except as otherwise provided in paragraphs 9.9(1)*"f"* and *"g,"* a subject has a right of access to inspect or to obtain a copy of the protected health information about the subject that is maintained in a designated record set. Subjects shall submit all requests for access to the department using Form 470-3952, Request for Access to Health Information.

If the department does not maintain the protected health information that is the topic of the subject's request for access, and the department knows where the requested information is maintained, the department shall inform the subject where to direct the request for access.

b. Timely action.

(1) The department shall act on a request for access no later than 30 days after receipt of the request unless the protected health information is not maintained or accessible to the department on site.

(2) If the requested information is not maintained or accessible to the department on site, the department shall take action no later than 60 days from the receipt of the request.

(3) If the department is unable to act within 30 days or 60 days as appropriate, the department may extend the time for the action by no more than 30 days. Within the applicable time limit, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department will complete its action on the request. The department shall have only one extension of time for action on a request for access.

c. Action on providing access. If the department grants the request, in whole or in part, the department shall inform the subject that the request is accepted and shall provide the access requested. Access includes inspecting the protected health information about the subject in designated record sets, obtaining a copy of the information, or both. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the department need only produce the protected health information once in response to a request for access.

(1) The department shall provide the subject with access to the protected health information in the form or format requested by the subject, if the requested format is readily producible. If the requested format is not readily producible, the department shall provide the information in a readable hard-copy form or other format as agreed to by the department and the subject.

(2) The department may provide the subject with a summary of the protected health information requested instead of providing access to the protected health information. The department may provide an explanation of the protected health information to which access has been provided. The subject must agree in advance to a summary or explanation and to any fees imposed by the department for the summary or explanation.

d. Time and manner of access. The department shall provide the access as requested by the subject in a timely manner as described in paragraph 9.9(1)*"b."* The department shall arrange with the subject for a time and place to inspect or obtain a copy of the protected health information that is convenient for both the subject and the department, or shall mail the copy of the protected health information at the subject's request. The department may discuss the scope, format, and other aspects of the request for access with the subject as necessary to facilitate the timely provision of access.

e. Fees for access. If the subject requests a copy of the protected health information or agrees to a summary or explanation of the information, the department may impose a reasonable, cost-based fee, as set forth in subrule 9.3(7).

f. Mandatory reasons for denial of access. The department shall deny a subject access to protected health information when the requested information is:

(1) Psychotherapy notes;

(2) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or

(3) Protected health information maintained by the department that is:

1. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. Section 263a, to the extent the provision of access to the subject would be prohibited by law; or

2. Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

g. Optional reasons for denial of access. The department may deny a subject access in the following circumstances.

(1) The department may temporarily suspend a subject's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment. The subject must have agreed to the denial of access when consenting to participate in the research that includes treatment. The suspension may last for as long as the research is in progress. The department shall inform the subject that the right of access will be reinstated upon completion of the research.

(2) The department may deny a subject's access to protected health information that is contained in records that are subject to the Privacy Act, 5 U.S.C. Section 552a, if the denial of access under the Privacy Act would meet the requirements of that law.

(3) The department may deny a subject's access if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

(4) State or federal law prohibits a subject's access to protected health information, such as the state law limitations described in subrule 9.9(2).

(5) The department may deny a subject access, provided that the subject is given a right to have the denials reviewed as required by paragraph 9.9(1)*"i,"* in the following circumstances:

1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the subject or another person;

2. The protected health information makes reference to another person (unless the other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to the other person; or

3. The request for access is made by the subject's personal representative, subject to the more restrictive definition of personal representative for protected health information, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to the personal representative is reasonably likely to cause substantial harm to the subject or another person.

h. Action on denial of access. If the department denies access, in whole or in part, to protected health information, the department shall comply with the following requirements.

(1) The department shall, to the extent possible, give the subject access to any other protected health information requested, after excluding the protected health information to which the department has a reason to deny access.

(2) The department shall provide a timely, written denial to the subject, in accordance with paragraph 9.9(1)*"b."*

i. Review of denial of access. If access is denied for a reason permitted under subparagraph 9.9(1)*"g"*(5), a subject may submit a written request for a review of a denial. If the subject requests a review, the department shall promptly refer the request to a licensed health care professional who is designated by the department to act as a reviewing official and who did not participate in the original decision to deny.

(1) The designated reviewing official shall determine, within 30 days, whether or not to deny the access requested based on the standards in subparagraph 9.9(1)*"g"*(5).

(2) The department shall promptly provide written notice to the subject of the determination made by the designated reviewing official and shall take other action as required to carry out the designated reviewing official's determination.

9.9(2) *Access by subjects to other confidential information.* The department shall release confidential records to the subject of the record. However, when a record has multiple subjects with interest in the confidentiality of the record, the department may take reasonable steps to protect confidential information relating to another subject. The department need not release the following records to the subject:

a. Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

b. The identity of a person reporting suspected abuse to the department need not be disclosed to the subject. (See 441—subrule 175.41(2) and Iowa Code section 235A.19.)

c. The identity of a person providing information to the department need not be disclosed directly or indirectly to the subject of the information when that information is authorized to be held confidential pursuant to Iowa Code section 22.7(18).

d. Peace officers' investigative reports may be withheld from the subject, pursuant to Iowa Code section 22.7(5).

e. The department may withhold disclosure of confidential information when the department has reason to believe that disclosure of the information would cause substantial and irreparable harm and would not be in the public interest. The department may withhold disclosure to seek an injunction to restrain examination of the record according to procedures in Iowa Code section 22.8 or to notify the person who would be harmed to allow that person to seek an injunction.

f. The department may withhold information as otherwise authorized by law.

441—9.10(17A,22) Use and disclosure without consent of the subject. Open records are routinely disclosed without the consent of the subject. To the extent allowed by law, the department may also use and disclose confidential information without the consent of the subject or the subject's representative.

9.10(1) *Internal use.* Confidential information may be disclosed to employees and agents of the department as needed for the performance of their duties. The custodian of the record shall determine what constitutes legitimate need to use confidential records.

People affected by this rule include:

1. County-paid staff, field work students, and volunteers working under the direction of the department.
2. Council and commission members.
3. Policy review and advisory committees.
4. Consultants to the department.

9.10(2) *Audits and health oversight activities.*

a. *Audits.* Information concerning program expenditures and client eligibility is released to staff of the state executive and legislative branches who are responsible for ensuring that public funds have been managed correctly. Information is also released to auditors from federal agencies when those agencies provide program funds.

b. *Health oversight activities.* The department shall disclose protected health information to the Secretary of Health and Human Services to investigate or determine the department's compliance with federal HIPAA regulations.

(1) Except as specified in paragraph 9.10(2)*"c,"* the department may also use protected health information, or disclose it to a health oversight agency, for other health oversight activities authorized by law. Health oversight activities include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

1. The health care system;
2. Government benefits programs for which protected health information is relevant to client eligibility;
3. Organizations subject to government regulatory programs for which protected health information is necessary for determining compliance with program standards; or
4. Organizations subject to civil rights laws for which protected health information is necessary for determining compliance.

(2) If a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation shall be considered a health oversight activity for purposes of subrule 9.10(2).

c. Exception to health oversight activities. For the purpose of the disclosures permitted by paragraph 9.10(2)*"b,"* a health oversight activity shall not include an investigation or other activity in which the subject is also the subject of the investigation or activity, unless the investigation or other activity directly relates to:

(1) The receipt of health care;

(2) A claim for public health benefits; or

(3) Qualification for or receipt of public benefits or services, when a patient's health is integral to the claim for public benefits or services.

9.10(3) *Program review.* Information concerning client eligibility and benefits is released to state or federal officials responsible for determining whether the department is operating a program lawfully. These officials include the citizens' aide office under Iowa Code section 2C.9, the auditor of state under Iowa Code section 11.2, the Office of Inspector General in the federal Department of Health and Human Services, and the Centers for Medicare and Medicaid Services.

9.10(4) *Contracts and agreements with agencies and persons.*

a. The department may enter into contracts or agreements with public or private agencies, such as the department of inspections and appeals, and business associates, such as, but not limited to, the Iowa Medicaid enterprise units, in order to carry out the department's official duties. Information necessary to carry out these duties may be shared with these agencies. The department may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the department obtains satisfactory assurance that the business associate will appropriately safeguard the information.

b. The department may enter into agreements to share information with agencies administering federal or federally assisted programs which provide assistance or services directly to persons on the basis of need. Only information collected in the family investment program, the child care assistance program, the food assistance program, the refugee resettlement program, or the child support recovery program may be shared under these agreements.

c. To meet federal income and eligibility verification requirements, the department has entered into agreements with the department of workforce development, the United States Internal Revenue Service, and the United States Social Security Administration.

The department obtains information regarding persons whose income or resources are considered in determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, child care assistance, food assistance, Medicaid, state supplementary assistance and foster care. Identifying information regarding clients of these programs is released to these agencies. The information received may be used for eligibility and benefit determinations.

d. To meet federal requirements under the Immigration Reform and Control Act of 1986 (IRCA) relating to the Systematic Alien Verification for Entitlements (SAVE) program, the department has entered into an agreement with the Bureau of Citizenship and Immigration Service (BCIS). Under the agreement, the department exchanges information necessary to verify alien status for the purpose of determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, food assistance, Medicaid, state supplementary assistance and foster care assistance. Identifying information regarding these subjects is released to the BCIS. The information received may be used for eligibility and benefit determinations.

e. The department has entered into an agreement with the department of workforce development to provide services to family investment program clients participating in the PROMISE JOBS program as described at 441—Chapter 93. Information necessary to carry out these duties shall be shared with the department of workforce development, as well as with its subcontractors.

The department has entered into an agreement with the department of human rights to provide services to family investment program clients participating in the family development and self-sufficiency program as described at 441—Chapter 165. Information necessary to carry out these duties shall be shared with the department of human rights, as well as with that agency's subcontractors.

f. State legislation requires that all emergency assistance households apply for and accept benefits for which they may qualify from the energy assistance, county general relief and veteran's

affairs programs before approval for emergency assistance. To meet this requirement, the department may enter into agreements with the agencies that administer these programs under which they may provide services to emergency assistance households as described at 441—Chapter 58. Information necessary to carry out these duties shall be shared with these agencies.

g. The department has entered into an agreement with the department of education, vocational rehabilitation, disability determination services, to assist with Medicaid disability determinations.

h. The department has entered into an agreement with the department of education to share information that assists both schools and department clients in carrying out the annual verification process required by the United States Department of Agriculture, Food and Nutrition Service. That federal agency requires the department of education and local schools to verify eligibility of a percentage of the households approved for free-meal benefits under the school lunch program.

When a department office receives a written request from the local school, the department office responds in writing with the current family investment program and food assistance program status of each recipient of free meals listed in the request. Other client-specific information is made available only with written authorization from the client.

9.10(5) *Release for judicial and administrative proceedings.* Information is released to the court as required in Iowa Code sections 125.80, 125.84, 125.86, 229.8, 229.10, 229.13, 229.14, 229.15, 229.22, 232.48, 232.49, 232.52, 232.71B, 232.81, 232.97, 232.98, 232.102, 232.111, 232.117 and 235B.3.

a. The department may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the department discloses only the protected health information expressly authorized by the order and the court makes the order knowing that the information is confidential.

b. When a court subpoenas information that the department is prohibited from releasing, the department shall advise the court of the statutory and regulatory provisions against disclosure of the information and shall disclose the information only on order of the court.

9.10(6) *Fraud.* Information concerning suspected fraud or misrepresentation to obtain department services or assistance is disclosed to the department of inspections and appeals and to law enforcement authorities.

9.10(7) *Service referrals.* Information concerning clients may be shared with purchase of service providers under contract to the department.

a. Information concerning the client's circumstances and need for service is shared with prospective providers to obtain placement for the client. If the client is not accepted for service, all written information released to the provider shall be returned to the department.

b. When the information needed by the provider is mental health information or substance abuse information, the subject's specific consent is required in subrule 9.3(4).

9.10(8) *Medicaid billing.* Only the following information shall be released to bona fide providers of medical services in the event that the provider is unable to obtain it from the subject and is unable to complete the Medicaid claim form without it:

a. Patient identification number.

b. Health coverage code as reflected on the subject's medical card.

c. The subject's date of birth.

d. The subject's eligibility status for the month that the service was provided.

e. The amount of spenddown.

f. The bills used to meet spenddown.

9.10(9) *County billing.* Information necessary for billing is released to county governments that pay part of the cost of care for intermediate care facility services for the mentally retarded under 441—subrule 82.14(2) or Medicaid waiver services under rule 441—83.70(249A) or 441—83.90(249A). This information includes client names, identifying numbers, provider names, number of days of care, amount of client payment, and amount of payment due.

9.10(10) *Child support recovery.* The child support recovery unit has access to information from most department records for the purpose of establishing and enforcing support obligations. Information about absent parents and recipients of child support services is released according to the provisions of

Iowa Code chapters 234, 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, 252K, 598, 600B, and any other support chapter. Information is also released to consumer reporting agencies as specified in rule 441—95.12(252B).

9.10(11) *Refugee resettlement program.* Contacts with both sponsor and resettlement agencies are made as a part of the verification process to determine eligibility or the amount of assistance. When a refugee applies for cash or Medicaid, the refugee's name, address, and telephone number are given to the refugee's local resettlement agency.

9.10(12) *Abuse investigation.* The central abuse registry disseminates child abuse information and dependent adult abuse information as provided in Iowa Code sections 235A.15 and 235B.7, respectively. Reports of child abuse and dependent adult abuse investigations are submitted to the county attorney as required in Iowa Code sections 232.71B and 235B.3. Results of the investigation of a report by a mandatory reporter are communicated to the reporter as required in Iowa Code sections 235A.17(2) and 235A.15(2)*"b"*(5).

9.10(13) *Foster care.* Information concerning a child's need for foster care is shared with foster care review committees or foster care review boards and persons named in the case permanency plan.

9.10(14) *Adoption.* Adoptive home studies completed on families who wish to adopt a child are released to licensed child-placing agencies, to the United States Immigration and Naturalization Service, and to adoption exchanges. Information is released from adoption records as provided in Iowa Code sections 600.16 and 600.24.

9.10(15) *Disclosures to law enforcement.*

a. *Disclosures by workforce members who are crime victims.* The department is not considered to have violated the requirements of this chapter if a member of its workforce who is the victim of a criminal act discloses confidential information to a law enforcement official, provided that:

(1) The confidential information disclosed is about the suspected perpetrator of the criminal act and intended for identification and location purposes; and

(2) The confidential information disclosed is limited to the following information:

1. Name and address.
2. Date and place of birth.
3. Social security number.
4. ABO blood type and Rh factor.
5. Type of injury.
6. Date and time of treatment.
7. Date and time of death, if applicable.
8. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

b. *Crime on premises.* The department may disclose to a law enforcement official protected health information that the department believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the department.

c. *Decedents.* The department may disclose protected health information to a law enforcement official about a subject who has died when the death resulted from child abuse or neglect or the death occurred in a department facility.

d. *Other.* The department may disclose confidential information to a law enforcement official when otherwise required or allowed by this chapter, such as disclosures about victims of child abuse or neglect; disclosures to avert a threat to health or safety, or to report suspected fraud; disclosures required by due process of law, such as disclosures for judicial and administrative proceedings; or other disclosures required by law.

9.10(16) *Response to law enforcement.* The address of a current recipient of family investment program benefits may be released upon request to a federal, state or local law enforcement officer if the officer provides the name of the recipient, and the officer demonstrates that:

a. The recipient is a fugitive felon who is fleeing prosecution, custody or confinement after conviction under state or federal law, or who is a probation or parole violator under state or federal law, or

b. The recipient has information that is necessary for the officer to conduct the officer's official duties, and

c. The location or apprehension of the recipient is within the officer's official duties.

9.10(17) *Research.* Information that does not identify individual clients may be disclosed for research purposes with the consent of the division administrator responsible for the records. The division administrator shall investigate the credentials of the researcher.

a. Mental health information may be disclosed for purposes of scientific research as provided in Iowa Code section 228.5, subsection 3, and section 229.25. Requests to do research involving records of a department facility shall be approved by the designated authority.

b. Abuse registry information may be disclosed for research purposes as provided in rules 441—175.42(235A) and 441—176.11(235B) and authorized by Iowa Code sections 235A.15(2)*"e"*(1) and 235B.6(2)*"e"*(1).

c. For research relating to protected health information, the researcher shall provide the department with information about the nature of the research, the protocol, the type of information being requested, and any other relevant information that is available concerning the request. If the researcher feels that contact with the subject is needed, the researcher shall demonstrate to the department that the research cannot be conducted without contact with the subject. The researcher shall pay for the costs of obtaining authorizations needed to contact the subjects and for the cost of files and preparation needed for the research.

9.10(18) *Threat to health or safety.*

a. All programs. A client's name, identification, location, and details of a client's threatened or actual harm to department staff or property may be reported to law enforcement officials. Other information regarding the client's relationship to the department shall not be released.

When a department staff person believes a client intends to harm someone, the staff person may warn the intended victim or police or both. Only the name, identification, and location of the client and the details of the client's plan of harm shall be disclosed.

b. Protected health information. The department may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the department, in good faith, believes the use or disclosure:

(1) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(2) Is necessary for law enforcement purposes as described in this chapter.

c. When the department uses or discloses protected health information pursuant to paragraph 9.10(18)*"b,"* the department is considered to have acted in good faith if the action is based on the department's actual knowledge or on a credible representation by a person with apparent knowledge or authority.

9.10(19) *Required by law.*

a. Information is shared with other agencies without a contract or written agreement when federal law or regulations require it.

b. The department may use or disclose protected health information to the extent that use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.

c. State law shall preempt rules in this chapter about protected health information when any one of the following conditions exists:

(1) Exception granted by Secretary of Health and Human Services. A determination is made by the Secretary of Health and Human Services under 45 CFR 160.204 as amended to August 14, 2002, that the provision of state law:

1. Is necessary:

- To prevent fraud and abuse related to the provision of or payment for health care;
- To ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation;

- For state reporting on health care delivery or costs; or
- For purposes of serving a compelling need related to public health, safety, or welfare, and, if a requirement under this chapter is at issue, the Secretary of Health and Human Services determines that the intrusion into privacy is warranted when balanced against the need to be served; or

2. Has as its principal purpose, the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances, as defined in 21 U.S.C. 802, or that is deemed a controlled substance by state law.

(2) State law more stringent. The provision of state law relates to the privacy of protected health information and is more stringent than a requirement of this chapter, within the meaning of "more stringent" found at 45 CFR 160.202 as amended to August 14, 2002.

(3) Reporting requirements. The provision of state law, including state procedures established under the law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

(4) Requirements related to audits, monitoring, evaluation, licensing, and certification. The provision of state law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities and persons.

9.10(20) *School attendance.* Rescinded IAB 7/7/04, effective 7/1/04.

9.10(21) *Treatment, payment, or health care operations.*

a. The department may use or disclose protected health information for treatment, payment, or health care operations, as described in this paragraph, except for psychotherapy notes, which are subject to the limits described in paragraph 9.10(21)*"b."* The use or disclosure shall be consistent with other applicable requirements of this chapter.

(1) The department may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) The department may disclose protected health information for treatment activities of a health care provider.

(3) The department may disclose protected health information to another covered entity or a health care provider for the payment activities of the person or organization that receives the information.

(4) The department may disclose protected health information to another covered entity for health care operations activities of the covered entity that receives the information, if each covered entity either has or had a relationship with the person who is the subject of the protected health information being requested, the protected health information pertains to the relationship, and the disclosure is:

1. For a purpose listed in numbered paragraph "1" or "2" of the definition of health care operations in 45 CFR 164.501 as amended to August 14, 2002; or

2. For the purpose of health care fraud and abuse detection or compliance.

b. The department may use or disclose psychotherapy notes without an authorization for any one of the following reasons:

(1) To carry out the following treatment, payment, or health care operations:

1. Use by the originator of the psychotherapy notes for treatment.

2. Use or disclosure by the department for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

3. Use or disclosure by the department to defend itself in a legal action or other proceeding brought by the subject.

(2) When required by the Secretary of Health and Human Services to investigate or determine the department's compliance with federal HIPAA regulations.

(3) For health oversight activities, as described at subrule 9.10(2), with respect to the oversight of the originator of the psychotherapy notes.

(4) When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public as described at subrule 9.10(18).

(5) When required by law as described at subrule 9.10(19).

(6) To disclose protected health information in the designated record set to a coroner or medical examiner as described at subrule 9.10(24).

9.10(22) *Public health activities.* The department may disclose protected health information for the public health activities and purposes described in this subrule. This disclosure is in addition to any other disclosure to a public health authority allowed by this chapter, such as a disclosure to report child abuse or neglect. For the purposes of this subrule, a public health authority includes state and local health departments, the Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention.

a. The department may disclose protected health information to a public health authority that is authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

(1) The information that may be disclosed includes, but is not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.

(2) At the direction of a public health authority, the department may also report this information to an official of a foreign government agency that is acting in collaboration with a public health authority.

b. The department may disclose protected health information to a person or organization that is subject to the jurisdiction of the FDA for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person or organization has responsibility. These purposes include:

(1) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product).

(2) To track FDA-regulated products.

(3) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying subjects who have received products that have been recalled, withdrawn, or are the subject of lookback).

(4) To conduct postmarketing surveillance.

c. The department may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition. The disclosure must be necessary to carry out public health interventions or investigations or to notify a person that the person has been exposed to a communicable disease to prevent or control the spread of the disease.

9.10(23) *Victims of domestic violence.* The department shall disclose confidential information about an individual whom the department reasonably believes to be a victim of domestic violence when required by state law.

9.10(24) *Disclosures to coroners, medical examiners, and funeral directors.*

a. *Coroners and medical examiners.* The department may disclose protected health information about a subject that is contained in the designated record set to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

b. *Funeral directors.* The department may disclose protected health information about a subject that is contained in the designated record set to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the department may disclose the protected health information before, and in reasonable anticipation of, the subject's death.

9.10(25) *Disclosures for cadaveric organ, eye or tissue donation purposes.* The department may disclose protected health information about a subject that is contained in the designated record set to organ procurement organizations or other organizations engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation. The department shall make a disclosure only when the disclosure has been approved by the deceased subject's authorized legal representative and there is evidence that the decedent had given approval for organ, eye, or tissue donation procedures before the decedent's death.

9.10(26) *Specialized government functions.* Protected health information may be shared under the circumstances described at 45 CFR 164.512, paragraph *"k,"* as amended to August 14, 2002, if

otherwise allowable under state law, such as sharing protected health information with the Social Security Administration in determining Medicaid eligibility for supplemental security income applicants and recipients.

9.10(27) *Whistle blowers.* The department is not considered to have violated the requirements of this chapter when a member of its workforce or a business associate discloses protected health information, provided that:

a. The workforce member or business associate has a good-faith belief that the department or a business associate has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or has provided care, services, or conditions that potentially endanger one or more patients, workers, or the public; and

b. The disclosure is made to one of the following:

(1) A health oversight agency or public health authority authorized by law to investigate or oversee conduct or conditions for the purpose of reporting the allegation of failure to meet professional standards or misconduct.

(2) An appropriate health care accreditation organization.

(3) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate.

9.10(28) *Secondary to a use or disclosure of protected health information.* The department may use or disclose protected health information that is secondary to a use or disclosure otherwise permitted or required by these rules, such as when a visitor in a facility overhears a doctor speaking to a subject about the subject's health.

9.10(29) *De-identified data or a limited data set.*

a. De-identified information. The department may use or disclose protected health information to create information that is de-identified under the conditions specified in 45 CFR 164.514, paragraphs *"a"* through *"c,"* as amended to August 14, 2002.

b. Limited data set. The department may use or disclose a limited data set under the conditions specified at 45 CFR 164.514, paragraph *"e,"* as amended to August 14, 2002, when the department enters into a data use agreement for research, public health, or health care operations.

441—9.11(22) Availability of records. This rule lists the department records which are open to the public, those which are confidential, and those which are partially open and partially confidential.

Department records are listed by category according to the legal basis for confidential treatment (if any). A single record may contain information from several categories.

The department administers several federally funded programs and is authorized by Iowa Code section 22.9 to enforce confidentiality standards from federal law and regulation as required for receipt of the funds. Where federal authority is cited in this rule, the department has determined that the right to examine and copy public records under Iowa Code section 22.2 would cause the denial of funds, services, or essential information from the United States government that would otherwise be available to the department.

The chart indicates whether the records in this category contain personally identifiable information and indicates the legal authority for confidentiality and for the collection of personally identifiable information.

Abbreviations are used in the chart as follows:

Code	Meaning
O	The records are open for public inspection.
C	The records are confidential and are not open to public inspection.
O/C	The record is partly open and partly confidential.
PI	Personally identifiable information
NA	Not applicable

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
Records of council, commission and statutory committees	O/C	Iowa Code 21.5(4)	No	NA
Pharmaceutical and therapeutics committee records (including information related to the prices manufacturers or wholesalers charge for pharmaceuticals)	O/C	42 U.S.C. §1396r(8)(b)(3)(D) and Iowa Code 550	No	NA
Rule making	O	NA	No	NA
Declaratory order records	O/C	Iowa Code 217.30	No	NA
Rules and policy manuals	O	NA	No	NA
State plans	O	NA	No	NA
Publications	O	NA	No	NA
Statistical reports	O	NA	No	NA
Financial and administrative records	O	NA	No	NA
Personnel records	O/C	Iowa Code 22.7(11)	Yes	Iowa Code 217.1
Contracts and interagency agreements	O	NA	No	NA
Grant records				
• Child abuse prevention	O	NA	No	NA
• Mental health/mental retardation general allocation	O	NA	No	NA
• Mental health/mental retardation special allocation	O	NA	No	NA
• Developmental disabilities basic	O	NA	No	NA
• Alcohol/drug abuse/mental health block	O	NA	No	
• National Institute of Mental Health	O	NA	No	
• Pregnancy prevention	O	NA	No	NA
• Juvenile community-based services	O	NA	No	NA
• Runaway prevention	O	NA	No	NA
Collection service center payment records	C	Iowa Code 252B.9(2); 42 U.S.C. §654a(d); 45 CFR §307.13	Yes	Iowa Code 252B.9, 252B.13A, 252B.16
Licensing, registration and approval				
• Juvenile detention and shelter care facilities	O/C	Iowa Code 217.30	No	NA
• Adoption investigators	O	NA	Yes	Iowa Code 600.2
• Supervised apartment living arrangement	O	NA	No	NA
• Mental health providers	O	NA	No	NA
• Family-life homes	O/C	Iowa Code 217.30	Yes	Iowa Code 234.6
• Foster care facilities	O/C	Iowa Code 237.9	Yes	Iowa Code 237
• Child care facilities	O/C	Iowa Code 237A.7	Yes	Iowa Code 237A
• Child-placing agencies	O/C	Iowa Code 238.24	No	NA
• Health care facilities	O/C	Iowa Code 135C.19	No	NA
Appeal records	O/C	Iowa Code 217.30	Yes	Iowa Code 217.1
Litigation files	O/C	Iowa Code 217.30, 22.7(4), 622.10	Yes	Iowa Code 217.1
Service provider records				
• Purchase of service providers	O/C	Iowa Code 217.30	Yes	Iowa Code 234.6
• Medicaid providers	O/C	Iowa Code 217.30, 42 U.S.C. §1396a(7), 42 CFR 431.300 to 307 as amended to November 13, 1996	Yes	Iowa Code 249A.4
• Residential care facilities	O/C	Iowa Code 217.30	No	NA
All service or assistance client records	C	Iowa Code 217.30	Yes	Iowa Code 217.1

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
• Family investment program	C	Iowa Code 217.30; 42 U.S.C. §602(a)(1) and §1306a	Yes	Iowa Code 239B
• Child care assistance	C	Iowa Code 237A.13	Yes	Iowa Code 237A
• State Supplementary Assistance	C	Iowa Code 217.30	Yes	Iowa Code 249
• Medicaid	C	Iowa Code 217.30; 42 U.S.C. §1396a(7); 42 CFR 431.300 to 307 as amended to November 13, 1996	Yes	Iowa Code 249A.4
• HAWK-I	C	Iowa Code 514I; 42 CFR 457.1110 as amended to January 11, 2001	Yes	Iowa Code 514I.4
• Food assistance	C	Iowa Code 217.30; 7 U.S.C. §2020(e)8 and 7 CFR 272.1 (c) and (d) as amended to January 1, 1987	Yes	Iowa Code 234.6
• Foster care	C	Iowa Code 237.9	Yes	Iowa Code 237.3 to 237.5
• Title IV-E foster care and adoption assistance	C	Iowa Code 217.30; 42 U.S.C. §671(a)(8); 45 CFR 1355.30(1) as amended to November 23, 2001	Yes	Iowa Code 217.1, Iowa Code 600.17 to 600.22
• Refugee resettlement	C	Iowa Code 217.30; 45 CFR 400.27 as amended to March 22, 2000	Yes	Iowa Code 217.1
• Substance abuse	C	Iowa Code 125.37 and 125.93; 42 U.S.C. §29 dd. 3 and ee. 3; 42 CFR Part 2 as amended to October 1, 2002; 38 U.S.C. §4132	Yes	Iowa Code 125, 218, 219 and 234.6 and 249A.4
• State institution resident records	C	Iowa Code 218.22, 229.24 and 229.25	Yes	Iowa Code 218.1
Program records				
• Child support recovery	C	Iowa Code 252B.9 and 252G.5; 42 U.S.C. §654(26), 42 U.S.C. §654a(d); 45 CFR §303.21 and 307.13	Yes	Iowa Code 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, 252K, and 144.13, 144.26, 232.147, 234.39, 595.4, 598.22B, and 600.16A
• Child abuse	C	Iowa Code 235A.13, 235A.15, 235A.16, and 235A.17	Yes	Iowa Code 235A.14
• Dependent adult abuse	C	Iowa Code 235B.1, par 4(a)	Yes	Iowa Code 235B.1
• Adoption	C	Iowa Code 600.16 and 600.24	Yes	Iowa Code 600.8 and 600.16
Client records may contain information from restricted sources:				
• Federal tax returns	C	Iowa Code 422.20(2); 26 U.S.C. §6103	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A, 252B
• Department of revenue	C	Iowa Code 421.17, 422.20(1)	Yes	Iowa Code 252B.5 and 252B.9
• Department of workforce development	C	Iowa Code 217.30; 42 U.S.C. §503(d) and (e)	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A, 249C, 252B.9
• Income and eligibility verification system	C	Iowa Code 217.30; 42 U.S.C. §1230b-7	Yes	Iowa Code 217.1, 234.6(7), 239B, 249A

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
• Department of public safety	C	Iowa Code 692.2, 692.3, 692.8 and 692.18	Yes	Iowa Code 237.8, 237A.5, 252B.9
• United States Department of Health and Human Services	C	Iowa Code 217.30; 42 CFR Part 401.134(c) as amended to October 1, 2002	Yes	Iowa Code 217.1, 234.6(7), 239B, 249, 249A, 252B
• Peer review organization	C	Iowa Code 217.30; 42 U.S.C. §1320c-9	Yes	Iowa Code 249A.4
• Juvenile court	C	Iowa Code 232.48, 232.97 and 232.147 to 232.151	Yes	Iowa Code 232 and 234.6
Other information				
• Mental health information	C	Iowa Code 228.2(1)	Yes	Iowa Code 217, 219, 222, 229
• Information received by a licensed social worker	C	Iowa Code 154C.5	Yes	Iowa Code 217.1
• Debtors to the department	C	Iowa Code 537.7103(3)	Yes	Iowa Code 217.1
• Health care facility complaint and citation records	C	Iowa Code 135C.19	No	Iowa Code 249A.4, 135C.19
• Hospital records, medical records, and professional counselor records	C	Iowa Code 22.7(2)	Yes	Iowa Code 218, 219, 222, 229
• Privileged communication and work products of attorneys representing the department	C	Iowa Code 22.7(4), Iowa Code of Professional Responsibility for Lawyers, Canon 4	No	NA
• Identity of volunteer informant who does not consent to release	C	Iowa Code 22.7(18)	No	Iowa Code 217.1
• School records	C	Iowa Code 22.7(1)	Yes	Iowa Code 218.1 and 234.6
• Library circulation records	C	Iowa Code 22.7(13) and (14)	No	Iowa Code 217.1
• Sealed bids prior to public opening	C	Iowa Code 72.3	No	NA
• Protected health information	C	HIPAA	Yes	Iowa Code 218.1, 249A.4, 514I.4

[**ARC 1262C**, IAB 1/8/14, effective 3/1/14]

441—9.12(22,252G) Personally identifiable information. The confidentiality provisions affecting records described in this rule are addressed in rule 441—9.11(22).

9.12(1) *Nature and extent.* The personally identifiable information collected by the department varies by the type of record. The nature and extent of personally identifiable information is described below:

a. Recipients of assistance. Several different types of department records contain personally identifiable information about recipients of assistance programs such as food assistance, Medicaid, the family investment program, child care assistance, state supplementary assistance, refugee cash and medical assistance, and commodity supplemental foods.

(1) Client case file. Local office case files contain identifying information, demographic information, household composition, and income and resource information about applicants for and recipients of assistance, as well as any other persons whose circumstances must be considered in determining eligibility. Records may contain information about employment, disability, or social circumstances. Records identify the kind and amount of benefits received and what proof was obtained to verify the recipient's eligibility. Case files contain correspondence, appeal requests and decisions, and documentation of department actions.

(2) Local office administrative records. Client names and program data are kept in card files, appointment logs, worker case lists, and issuance records.

(3) Data processing systems. Client identifying information, eligibility data, and payment data are kept in the following systems. Some of these records are also kept on microfiche.

System	Function
Automated Benefit Calculation System	Determines eligibility for FIP, food assistance, Medicaid
Automated Child Abuse and Neglect System	Inactive child abuse/neglect system
Appeals Logging and Tracking System	Tracks client appeals
BCCT Program	Establishes Medicaid eligibility for breast and cervical cancer clients
Change Reporting System	Tracks client-reported changes and produces forms needed for client-reported changes
Diversion System	Tracks clients using diversion benefits
Electronic Payment Processing and Inventory Control System	Electronically issues food assistance
Eligibility Tracking System	Tracks clients' FIP eligibility and hardship status
Family and Children's Services System	Tracks foster care, adoption, family-centered and family preservation services
Food Stamps Case Reading Application	Food assistance accuracy tool used to record case reading information
Health Insurance Premium Payment System	Health insurance premium payment
Iowa Collection and Reporting System	Tracks child support recovery processes
Iowa Central Employee Registry	Child support new hire reporting system
Iowa Eligibility Verification System	Federal social security number verification and benefits
Iowa Plan Program	Assigns group codes for Iowa Plan clients
Individualized Services Information System	Used to establish facility eligibility, process data to and from ABC and Medicaid fiscal agent, establish waiver services, providers, and eligibility
Issuance History	Displays benefit issuances for FIP and food assistance
KACT System	Authorizes foster care service units
MEPD Premium Payment Program	Accounting system for billing and payment for Medicaid for employed people with disabilities program
Managed Health Care Program	Assigns managed health care providers to clients
Medicaid Management Information Systems	Process clients' Medicaid claims and assign Medicaid coverage to clients
Overpayment Recoupment System	Used to recover money from FIP, Food Assistance, Medicaid, Child Care Assistance, PROMISE JOBS, and HAWK-I clients
Public Information Exchange	Data exchange between states
PJCASE	Iowa Workforce Development interface with PROMISE JOBS
Purchase of Social Services System	Purchased services (mostly child care and in-home health clients)
Presumptive Eligibility Program	Establishes Medicaid eligibility for presumptive eligibility clients

System	Function
Quality Control System	Selects sample for quality control review of eligibility determination
RTS Claims Processing System	Processes rehabilitative treatment claims for federal match
State Data Exchange Display	State data exchange information for supplemental security income recipients
Social Security Buy-In System	Medicare premium buy-in
Social Services Reporting System	Services reporting system for direct and purchased services
Statewide Tracking of Assessment Reports	Tracks child abuse reports

(4) Quality control records. Files are developed containing data required to verify the correctness of department eligibility and benefit decisions for selected clients.

(5) Appeals. Records containing client eligibility and payment information are created by the department of inspections and appeals when a client (or, for Medicaid, a provider) requests a hearing on a department action.

(6) Fraud. When a client is suspected of fraud, the department of inspections and appeals generates an investigative record containing information pertinent to the circumstances of the case.

(7) Recoupment. When benefits have been overpaid, a record is established by the department of inspections and appeals concerning the circumstances of the overpayment and the client's repayment.

b. Recipients of social services. Several kinds of department records contain personally identifiable information about applicants for and recipients of direct or purchased social services.

(1) Client case records. Local offices create client case files containing identifying information and demographic information; income data; information substantiating the need for services, which may include medical, psychological or psychiatric reports; social history; the department evaluation of the client's situation; documentation of department actions; and provider reports. Records may contain court orders and reports.

(2) Local office administrative records. Client names and services data appear in records such as card files, case lists, and appointment logs.

(3) Data processing systems. Client identifying information, demographic data, and services eligibility data are stored in the service reporting system. The purchase of services system contains invoice and service payment data. The child and adult protection system contains information from abuse reports and investigations. Some of these records are also kept on microfiche.

(4) Appeals. Records containing client identifying information and eligibility information are created by the department of inspections and appeals when a client requests a hearing on a department action.

(5) Adoption records. The department keeps a master card file on all adoptions in Iowa as required in Iowa Code section 235.3, subsection 7. This record is also kept on microfilm.

The Iowa Adoption Exchange contains records on special needs children available for adoption and on families that have indicated an interest in adopting special needs children.

The department also keeps records on adoptions in which it has provided services. These files include the home study, information about the child, and legal documents. These records are also kept on microfiche.

(6) Abuse registry. Child and dependent adult abuse records contain names and information of the alleged victim and the victim's family, data on the reported abuse, details of injury, investigative data, name of alleged perpetrator, names of reporters, collateral contacts and findings.

(7) Interstate compact records. The department maintains records on placement of children across state lines. These records contain identifying information about the children and the conditions of their placement, as well as progress reports. Some of the records are kept on microfiche.

(8) Guardianship records. The department maintains records on all children under its guardianship. The records concern the children's characteristics and placements. Some of these records are kept on microfiche.

c. Institutions. Institution resident records may contain identifying and demographic information, medical and social histories, treatment records, treatment plans, educational information, admission procedures, financial accounts, county billings, residential unit notes, vocational information, economic data and information about personal effects. Some of this information is kept on microfiche.

Automated data processing systems associated with institutional client records include admission and discharge systems for the juvenile institutions and for the mental health and mental retardation institutions, institutional billing systems, client banking systems, and client data systems.

d. Child support recovery unit (CSRU) records. These records contain information such as client identifiers, demographic information, divorce decrees, child support orders, absent parent identifiers, employment history and physical characteristics of absent parents, payment history records, and termination of parental rights.

e. Collection services center. The collection services center maintains records of support orders issued or filed in Iowa that have been converted to the collection services center system. These records identify the person paying and the person receiving support, specify the support obligations, and contain a record of payments made. Most records are on an automated data processing system. Paper records may also be kept, including conversion documents, orders, and correspondence.

f. Contractor records for individual providers. Records of individual purchase of service and Medicaid providers contain information such as names of owners and employees, names of clients served, eligibility data, amounts of payment for clients, and kinds of services received by clients.

g. Regulatory files on individual providers. Files on persons who apply to be licensed, certified, registered, or approved by the department contain identifying information, a description of the person's operation or premises, and a department evaluation of the information collected. Files may contain data on criminal records and abuse registry records on the person and any employees. Files may contain information naming clients served (for example, in complaints or incident reports). Some of these records are also kept on microfilm.

h. Personnel files. The department maintains files containing information about employees, families and dependents, and applicants for paid or volunteer positions within the department. The files contain payroll records, biographical information, medical information pertaining to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding and information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship.

9.12(2) *Data processing matching.*

a. Internal. All data processing systems operated by the department which have comparable personally identifiable data elements permit the matching of personally identifiable information. (See subrule 9.12(1) for a description of these systems.) Matches which are routinely done include the following:

(1) Data from the service reporting system is matched with data from the purchase of service payment system for service eligibility and with the activity reporting system for cost allocation. Matches are also done with the state identification portion of the automated benefit calculation system.

(2) The automated benefit calculation system matches with the Medicaid eligibility system, the facility payment system, the child support collections system, the employment and training systems, the electronic payment processing and inventory control system, the eligibility tracking system, the Medicare buy-in system, the individualized services information system-waiver payment system, and the income eligibility and verification system.

(3) The Medicaid eligibility system matches information with the Medicaid management information system and the collection and recovery system.

b. External.

(1) The state data exchange matches information on department clients with records on recipients of supplemental security income.

(2) The Medicare buy-in system matches information with the Social Security Administration.

(3) The income and eligibility verification system matches information on department clients with income records from department of workforce development records on unemployment compensation and wages, tax records from the Internal Revenue Service, wage records and social security benefit records from the Social Security Administration, and public assistance records from other states.

(4) Data from the collections and reporting system is matched with state and federal tax records, and with client records on the automated benefit calculation system.

(5) Data on department clients is matched with the administering agency for the Workforce Investment Act and with private agencies working to help employers collect benefits under the work opportunity tax credit program.

(6) Reports on disqualified food stamp recipients from other states are received from the United States Department of Agriculture to ensure that recipients are not evading penalties by reapplying in Iowa.

(7) A list of recipients of benefits under the family investment program is released annually to the Internal Revenue Service for matching with records of dependents claimed.

(8) A list of applicants for and recipients of the family investment program (FIP), the Medicaid program, and the food assistance program is matched with records on Iowa motor vehicle registration files to assist in the identification of countable resources.

(9) The Medicaid management information system matches data on medical assistance recipients against data on insureds that is submitted by insurance carriers under rule 441—76.13(249A) in order to identify third-party payers for medical assistance recipients.

c. *Centralized employee registry (CER) database.* The CER receives data concerning employees and contractors who perform labor in Iowa. Information reported by Iowa employers about employees includes the employee's name, address, social security number, date of birth, beginning date of employment, whether health insurance is available, and when it may be available. Information reported by Iowa income payers about contractors is limited to the contractor's name, address, social security number, and date of birth, if known.

State agencies accessing the CER shall participate in proportionate cost sharing for accessing and obtaining information from the registry. Cost sharing shall include all costs of performing the match including costs for preparing the tapes and central processing unit time. Costs shall be specified in a 28E agreement with each agency. CER matches include the following data matches with:

(1) The child support collections and reporting system for the establishment and enforcement of child and medical support obligations.

(2) Other department of human services systems for the purpose of gathering additional information and verification for use in the determination of eligibility or calculation of benefits.

(3) The department of employment services for the determination of eligibility or calculation of unemployment benefits, and to monitor employer compliance with job insurance tax liability requirements.

(4) The department of workforce development to verify employment of participants in the PROMISE JOBS program.

(5) The department of revenue for the recoupment of debts to the state.

(6) The department of inspections and appeals for the recoupment of debts owed to the department of human services.

441—9.13(217) Distribution of informational materials.

9.13(1) *Requirements for distribution.* All material sent or distributed to clients, vendors, or medical providers shall:

a. Directly relate to the administration of the program.

b. Have no political implications.

c. Contain the names only of persons directly connected with the administration of the program.

d. Identify them only in their official capacity with the agency.

9.13(2) *Distribution prohibited.* The department shall not distribute materials such as holiday greetings, general public announcements, voting information, and alien registration notices.

9.13(3) *Distribution permitted.* The department may distribute materials directly related to the health and welfare of clients, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

441—9.14(17A,22) Special policies and procedures for protected health information.

9.14(1) *Minimum necessary.* When using or disclosing protected health information or when requesting protected health information from another covered entity, the department shall make reasonable efforts, as described in paragraphs 9.14(1)*"a"* through *"e,"* to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

a. This requirement does not apply in the following circumstances:

(1) Disclosures to or requests by a health care provider for treatment.

(2) Uses or disclosures made to the subject.

(3) Uses or disclosures made pursuant to an authorization.

(4) Disclosures made to the Secretary of Health and Human Services.

(5) Uses or disclosures that are required by law.

(6) Uses or disclosures that are required for compliance with this chapter.

b. The department shall take the following actions:

(1) Identify those persons or classes of persons, as appropriate, in its workforce who need access to protected health information to carry out their duties.

(2) For each person or class of persons, identify the category or categories of protected health information to which access is needed and any conditions appropriate to the access.

(3) Make reasonable efforts to limit the access of these persons or classes.

c. For any type of disclosure that it makes on a routine and recurring basis, the department shall implement policies and procedures (which may be standard protocols) that limit the amount of the protected health information disclosed to that reasonably necessary to achieve the purpose of the disclosure.

For all other disclosures, the department shall develop criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought. The department shall review requests for disclosure on an individual basis in accordance with the criteria.

The department may rely, if reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:

(1) Making permitted disclosures to a public official, provided the public official indicates that the information requested is the minimum necessary for the stated purposes;

(2) The information is requested by another covered entity; or

(3) The information is requested for the purpose of providing professional services to the department by a professional who is a workforce member or business associate of the department if the professional indicates that the information requested is the minimum necessary for the stated purpose.

d. Minimum necessary requests.

(1) When requesting information from other covered entities, the department shall limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made.

(2) For a request that is made on a routine and recurring basis, the department shall implement policies and procedures (which may be standard protocols) that limit the protected health information requested to the amount reasonably necessary to accomplish the purpose for which the request is made.

(3) For all other requests, the department shall develop criteria designed to limit the request for protected health information to the information reasonably necessary to accomplish the purpose for which the request is made and to review requests for disclosure on an individual basis in accordance with the criteria.

e. For all uses, disclosures, or requests to which the minimum necessary requirements apply, the department shall not use, disclose or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.

9.14(2) *Uses and disclosures for premium rating and related purposes.* If a health plan receives protected health information for the purpose of premium rating or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if the health insurance or health benefits are not placed with the health plan, the health plan shall not use or disclose the protected health information for any other purpose, except as may be required by law.

9.14(3) *Verification and documentation.*

a. Before any disclosure of protected health information, the department shall obtain verification or documentation as follows:

(1) Verify the identity of a person requesting protected health information and the person's authority to access protected health information, if the department does not know the identity or authority of the person. This requirement is waived for disclosures to persons involved in the subject's care or for notification purposes, as described at subrule 9.7(3).

(2) Obtain any oral or written documentation, including statements and representations, from the person requesting the protected health information when this is a condition of the disclosure under this chapter.

b. The following constitute appropriate verification or documentation, if reasonable under the circumstances:

(1) Documentation, statements, or representations. The department may rely on documentation, statements, or representations that, on their face, meet the applicable requirements.

(2) Identity of public officials. When disclosure of protected health information is requested by a public official or a person acting on behalf of the public official, the department may rely on any of the following to verify identity:

1. In-person presentation of an agency identification badge, other official credentials, or other proof of government status.

2. A written request on the appropriate government letterhead.

3. A written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes the person is acting on behalf of the public official.

(3) Authority of public officials. When the disclosure of protected health information is requested by a public official or a person acting on behalf of the public official, the department may rely on any of the following to verify authority:

1. A written statement of the legal authority under which the information is requested.

2. If a written statement would be impracticable, an oral statement of the legal authority.

3. An order issued by a judicial or administrative tribunal.

(4) Exercise of professional judgment. The requirements of this subrule are met if the department relies on the exercise of professional judgment in use or disclosure to persons involved in the subject's care or for notification purposes, in accordance with subrule 9.7(3), or acts on a good-faith belief in making a disclosure to avert a serious threat to health or safety, in accordance with subrule 9.10(18).

9.14(4) *Notice of privacy practices for protected health information.* A subject has a right to adequate notice of the uses and disclosures of protected health information that may be made by the department, and of the subject's rights and the department's legal duties with respect to protected health information.

9.14(5) *Right to receive an accounting of disclosures.* Within the limits described in this subrule, a subject has a right to receive an accounting of the disclosures of protected health information listed in paragraph 9.14(5)*"a,"* including disclosures to or by business associates of the department. A subject shall request an accounting using Form 470-3985, Request for a List of Disclosures.

a. Disclosures that may be included in an accounting. A subject's right to receive an accounting of disclosures made by the department, or to or by business associates of the department, is limited to the following disclosures that do not require an authorization or an opportunity for the subject to agree or object:

(1) For health oversight activities described at subrule 9.10(2).

(2) For judicial and administrative proceedings described at subrule 9.10(5).

(3) For law enforcement purposes described at subrule 9.10(15).

(4) For averting a threat to health or safety described at subrule 9.10(18).

(5) To meet requirements of law described at subrule 9.10(19).

(6) For public health activities described at subrule 9.10(22).

(7) For disclosures about suspected victims of domestic violence described at subrule 9.10(23).

(8) For disclosures about suspected victims of abuse or neglect described in 441—Chapter 9.

(9) To coroners, medical examiners, and funeral directors described at subrule 9.10(24).

(10) For cadaveric organ, eye, or tissue donation described at subrule 9.10(25).

(11) For specialized government functions described at subrule 9.10(26), except those made for national security or intelligence purposes.

(12) By whistle blowers as described at subrule 9.10(27).

b. Content of the accounting. The department shall provide the subject who submits Form 470-3985, Request for a List of Disclosures, with a written accounting of disclosures that meets the following requirements.

(1) The accounting shall include disclosures of protected health information that occurred during the six years (or the shorter time requested by the subject) before the date of the request. However, disclosures that occurred before April 14, 2003, are not included in an accounting.

(2) Except for limitations regarding multiple disclosures to the same person or organization, the accounting shall include for each disclosure:

1. The date of the disclosure.

2. The name of the organization or person who received the protected health information and, if known, the address of the organization or person.

3. A brief description of the protected health information disclosed.

4. A brief statement of the purpose of the disclosure that reasonably informs the subject of the basis for the disclosure or, instead of the statement, a copy of a written request for a disclosure.

(3) If, during the period covered by the accounting, the department has made multiple disclosures of protected health information to a person or organization requesting a disclosure, the accounting may, with respect to the multiple disclosures, provide:

1. The information required by subparagraph 9.14(5)*"b"*(2), for the first disclosure during the accounting period;

2. The frequency, periodicity, or number of the disclosures made during the accounting period; and

3. The date of the last disclosure during the accounting period.

c. Time limits for providing the accounting. The department shall act on the subject's request for an accounting no later than 60 days after receipt of a request, as follows:

(1) The department shall provide the subject with the accounting requested; or

(2) If the department is unable to provide the accounting within these 60 days, the department may extend the due date one time, for a period not to exceed 30 days. In order to extend the due date, the department shall provide the subject with a written statement of the reasons for the delay and the date by which the department shall provide the accounting. The department shall provide this written statement within the 60-day period after receipt of the request for an accounting.

d. Fee for accounting. The department shall provide to a subject one accounting without charge in any 12-month period. The department may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same subject within the 12-month period, as set forth in subrule 9.3(7), provided that the department:

(1) Informs the subject in advance of the fee; and

(2) Provides the subject with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

e. *Suspension of right.* The department shall temporarily suspend a subject's right to receive an accounting of disclosures made to a health oversight agency or law enforcement official, as permitted in this chapter, if the agency or official provides the department with a statement that the accounting would likely impede the agency's activities and specifies the time for which a suspension is required.

(1) If the agency or official statement is submitted in writing, the department shall suspend the right to receive accounting for the time specified by the agency or official.

(2) If the agency or official statement is made orally, the department shall:

1. Document the statement, including the identity of the agency or official making the statement;

2. Temporarily suspend the subject's right to an accounting of disclosures subject to the statement; and

3. Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless the agency or official statement is submitted in writing during that time.

9.14(6) *Complaint procedure.* A person who believes the department is not complying with the rules on protected health information or with the applicable requirements of 45 CFR Part 160 as amended to August 14, 2002, or with the applicable standards, requirements, and implementation specifications of 45 CFR of Subpart E of Part 164 as amended to August 14, 2002, may file a complaint with the department's privacy office or with the Secretary of Health and Human Services.

a. Complaints to the department's privacy office shall be in writing and may be delivered personally or by mail to the DHS Privacy Office, 1305 E. Walnut Street, First Floor, Des Moines, Iowa 50319-0114. Complaints regarding facilities may be sent to the applicable facility.

b. Complaints to the Secretary of Health and Human Services shall be made using the procedures set forth in 45 CFR 160.306 as amended to August 14, 2002.

9.14(7) *Appeal rights.*

a. If the subject disputes a decision by the privacy officer, the department's designated licensed health care professional, or the facility administrator on any of the following requests, the subject may appeal the decision in accordance with 441—Chapter 7.

(1) A request for restriction on use or disclosure of protected health information.

(2) A request for confidential communication of protected health information.

(3) A request for access to protected health information.

(4) A request to amend protected health information.

(5) A request for accounting of disclosures.

b. The privacy officer or facility shall assist the subject in making the appeal, if needed.

c. Appeals shall be:

(1) Mailed to the Appeals Section, Fifth Floor, Iowa Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114; or

(2) Submitted electronically at www.dhs.state.ia.us/appeals.asp.

9.14(8) *Record retention.* Notwithstanding any other department rule to the contrary, protected health information shall be retained for at least six years from the date of creation or the date when the information last was in effect, when required by 45 CFR 164.530, paragraph *"j,"* as amended to August 14, 2002.

441—9.15(17A,22) Person who may exercise rights of the subject.

9.15(1) *Adults.* When the subject is an adult, including an emancipated minor, the subject's rights under this rule may also be exercised by the subject's legal or personal representative, except as provided in subrule 9.15(3).

9.15(2) *Minors.* Within the limits of subrule 9.15(3), when the subject is an unemancipated minor, the subject's rights under this rule shall be exercised only by the subject's legal representative, except as follows:

a. When the department otherwise deals with the minor as an adult, as in the case of minor parents under the family investment program.

b. When otherwise specifically provided by law. However, minor subjects shall be granted access to their own records upon request, subject to the limits in rule 441—9.9(17A,22).

9.15(3) *Exceptions.*

a. Scope of authority. Legal and personal representatives may act only within the scope of their authority. For protected health information, the designation must reflect the subject's ability to make health care decisions and receive protected health information. For example, court-appointed conservators shall have access to and authority to release only the following information:

(1) Name and address of subject.

(2) Amounts of assistance or type of services received.

(3) Information about the economic circumstances of the subject.

b. Mental health information. Only an adult subject or a subject's legal representative may consent to the disclosure of mental health information. Records of involuntary hospitalization shall be released only as provided in Iowa Code section 229.24. Medical records of persons hospitalized under Iowa Code chapter 229 shall be released only as provided in Iowa Code section 229.25.

c. Substance abuse information. Only the subject may consent to the disclosure of substance abuse information, regardless of the subject's age or condition.

d. Failure to act in good faith. If the department has reason to believe that the legal or personal representative is not acting in good faith in the best interests of the subject, the department may refuse to release information on the authorization of the legal or personal representative.

e. Abuse, neglect, and endangerment situations. Notwithstanding a state law or any other requirement of this chapter, the department, in the exercise of professional judgment, may elect not to treat a person as a subject's personal representative if:

(1) The department has reason to believe that the subject has been or may be subjected to domestic violence, abuse, or neglect by the person; or

(2) The department has reason to believe that treating the person as a personal representative could endanger the subject.

f. Protected health information. A parent, guardian, or other person acting in place of a parent who does not represent the minor for protected health information may still access protected health information about the minor if required by law.

g. Deceased subjects. If, under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased subject or of the subject's estate, the department shall treat that person as a personal representative.

h. Other. If, under applicable law, the subject of a confidential record is precluded from having a copy of a record concerning the subject disclosed to a third party, the department shall not treat the third party as a personal representative.

These rules are intended to implement Iowa Code sections 17A.3, 22.11, 217.6 and 217.30, Iowa Code chapters 228 and 252G, and the Health Insurance Portability and Accountability Act of 1996.

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CHAPTER 10
INDIVIDUAL DEVELOPMENT ACCOUNTS
Rescinded IAB 12/2/09, effective 11/10/09

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define the department's policies regarding the collection of public assistance debts. These rules outline what information must be maintained for each claim for an overpayment or other debt owed the department and how the payments are to be applied. These rules also outline the criteria for withholding part or all of federal or state refunds or other state payments owed to the debtor and how they are applied to the debtor's claim for payment of the debt.

441—11.1(217) Definitions.

"Current" shall mean that amount which is due and owing within the previous 12 months from the date of submission to the department of administrative services or that amount which is due and owing from the date the repayment agreement or court order is implemented, if less than 12 months, before the date of submission to the department of administrative services.

"Current repayment" shall mean that payment of the cumulative sum due and owing in accordance with a repayment agreement or court order for the preceding 12 months or the date of the order or agreement if the order or agreement is more recent.

"Debtor" shall mean a current or former recipient of public assistance that has been determined by the department to be responsible for the repayment of a particular debt. For food assistance, "debtor" shall include all adult members of the food assistance household participating at the time the food assistance overpayment or program violation occurred and shall include nonrecipients found guilty of violating food assistance program rules by committing an act such as, but not limited to, trafficking. For child care assistance, "debtor" may include the current or former provider or current or former recipient of child care assistance. For Medicaid, "debtor" shall include any Medicaid member or nonmember who fraudulently receives services or owes a debt of unpaid premium payments for medical assistance.

"Department" shall mean the department of human services.

"Public assistance" shall mean family investment program, food assistance, Medicaid, state supplementary assistance, PROMISE JOBS, child care assistance, refugee cash assistance, IowaCare, and HAWK-I program.

"Repayment agreement" shall mean an agreement entered into voluntarily between the department and the debtor for the repayment of debts. Agreements shall be made on Form 470-0495, Agreement to Pay a Debt, or on a notice of debt listed in subrule 11.2(2).

"Written notification" shall mean the notification sent to a debtor by the department on Form 470-1668, Notice of Setoff of an Iowa Income Tax Refund for Debts Owed the Department of Human Services, Form 470-4139, Notice of Income Offset Against State Warrants, and Form 470-4140, Notice of Income (Payroll) Offset.

[**ARC 7829B**, IAB 6/3/09, effective 7/8/09; **ARC 9701B**, IAB 9/7/11, effective 9/1/11]

441—11.2(217) Establishment of claim.

11.2(1) *Accounts.* The department shall maintain an account for each debt that has occurred. The account shall contain the following:

a. A debtor name and account number.
b. Program in which the debt occurred.
c. Date the debt was discovered.
d. Inclusive dates of the debt.
e. Total dollar amount of each debt.
f. Primary cause of the debt.
g. Any transaction applied to this debt.

11.2(2) *Notice of debt.* A claim is established when the first notice of the debt is issued to the household on one of the following forms:

a. Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance (no longer issued).

b. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance (no longer issued).

c. Form 470-2891, Notice of Medical Assistance Overpayment.

d. Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance (no longer issued).

e. Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance (no longer issued).

f. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance (no longer issued).

g. Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.

h. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance (no longer issued).

i. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance (no longer issued).

j. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance (no longer issued).

k. Form 470-4179, Notice of Food Assistance Debt.

l. Form 470-4530, Notice of Child Care Assistance Overpayment.

m. Form 470-4668, Notice of Food Assistance Overpayment.

n. Form 470-4683, Notice of FIP or RCA Overpayment.

o. Form 470-4688, Notice of PROMISE JOBS Overpayment.

11.2(3) *Change in debt.* An additional notice of debt shall be issued if a change occurs in the amount or period of the debt.

11.2(4) *Collection action.* No collection action shall be initiated on:

a. A debt for which no notice of debt has been issued to the household.

b. A debt that is in appeal status.

c. A debt that is in suspended status due to an exception to policy.

[**ARC 7829B**, IAB 6/3/09, effective 7/8/09]

441—11.3(217) Application of payment. Payment shall be applied only to debts subject to collection pursuant to subrule 11.2(4).

11.3(1) *Application of payment to single program area.*

a. If there is more than one debt in a program, payment shall be applied:

(1) First to all debts which have an agreement in chronological order of discovery, and

(2) Then to debts which do not have an agreement in chronological order of discovery until all debts have been paid in full or the full payment amount has been exhausted.

b. For food assistance, payment shall be applied first to all debts with an agreement and then to debts without an agreement. Within those two groupings, payment shall be applied in the following order:

(1) First to state-only debts in chronological order of discovery,

(2) Then to intentional program violation (IPV) debts in chronological order of discovery,

(3) Then to inadvertent household error (IHE) debts in chronological order of discovery, and

(4) Then to agency error debts in chronological order of discovery.

11.3(2) *Application of payment to multiple program areas.* If there are debts in more than one program area of public assistance, payments received shall be applied to those program areas as indicated by the mode of repayment (food assistance benefits, FIP benefits) or as indicated by the client at the time of payment.

11.3(3) *Application of undesignated cash payment.* If an undesignated cash payment is received, it shall be applied to each program area proportionally based on the cumulative balance of all debts in all program areas combined.

11.3(4) *Application of payment prohibited.* Rescinded IAB 11/7/07, effective 11/1/07.

441—11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages.

11.4(1) *Criteria for setoff.*

a. A claim against a debtor may be made by the department for public assistance debts when:

(1) A debtor has failed to negotiate a repayment agreement for that program area of public assistance, or

(2) A repayment agreement is not current, and

(3) The cumulative balance of the applicable debts in 11.4(1)*"a"*(1) and (2) exceeds $50.

b. A claim against a debtor will not be made by the department for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through grant or benefit reduction.

11.4(2) *Frequency of submission.* The department shall submit to the department of administrative services twice each month a list of those debtors who have a debt meeting the criteria in subrule 11.4(1).

11.4(3) *Pre-setoff notice.* The department shall mail written notification to a debtor to inform the debtor of the amount the department intends to claim and apply to debts in each program when:

a. The department is notified by the department of administrative services that the debtor is entitled to a state income tax refund, rebate, or other state payment;

b. The department makes claim against the debtor.

11.4(4) *Method for division of joint payments.* When either spouse wishes to request a division of a jointly or commonly owned right to payment, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, the spouse's proportionate share of a jointly or commonly owned right to payment, as determined by the department of administrative services, shall be released by the department of administrative services unless:

a. Other claims are made on that portion of the jointly or commonly owned right to payment, or

b. That spouse was also a member of the same household and the spouse's income and resources were or should have been considered in the calculation of public assistance.

11.4(5) *Appeal rights.* When a debtor wishes to contest the claim of the department, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, a hearing shall be granted pursuant to rules in 441—Chapter 7.

a. If the department is upheld in the final decision, the setoff process shall continue and the refund, rebate, or other state payment shall be applied to the appropriate delinquent debts.

b. If the department is reversed in the final decision, the debtor's refund, rebate, or other state payment shall be released to the debtor by the department of administrative services.

11.4(6) *Debt setoff.* If the department has not received a request for an appeal hearing or a request for division of a jointly or commonly owned right to payment within 15 days after the date the written notification is mailed, the department shall notify a debtor of the final decision regarding the claim by mailing the Debt Setoff Credit Letter, Form 470-1667, to the debtor.

11.4(7) *Application of setoff.* The department shall apply any setoff received from the department of administrative services as a result of this rule to the debtor's debts as indicated on the written notification mailed to the debtor and in accordance with rule 441—11.3(217).

Any amount remaining after the setoff shall be released back to the individual.

441—11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages.

11.5(1) *Criteria for setoff.*

a. Debtors not participating in the food assistance program shall be subject to collection action through the treasury offset program (TOP) which includes, but is not limited to, federal salary offset and federal tax refund offset.

(1) Debtors shall be referred to TOP if they are delinquent in repaying their food assistance debt and there is a claim or combination of claims with an unpaid balance which exceeds $25.

(2) No claim which is less than three months old or more than ten years old as of January 31 of the offset year shall be referred. EXCEPTION: Claims which have had a final judgment entered are not subject to the ten-year time limit.

(3) Debtors are delinquent in repaying their food assistance debt if:

1. A repayment agreement has not been signed and 180 days have elapsed since the due date of the demand letter as defined in 441—subrule 65.21(4) minus any days the claim was not subject to collection action because of an appeal.

2. A repayment agreement has been signed but the debtor has failed to make the agreed-upon payments and has failed to make up the missed payments. The debtor shall be referred to TOP when 180 days have elapsed since the first of the month following the month that the debtor failed to make the agreed-upon payment and has not subsequently made up the missed payment.

b. A claim against an individual will not be referred to TOP by the department of inspections and appeals (DIA) for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through benefit reduction.

11.5(2) *Setoff under TOP.* DIA shall, by December 1 of each year, submit a notification of liability for delinquent claims to the Department of the Treasury.

11.5(3) *Pre-setoff notice.* DIA shall mail Form 470-3488, Treasury Offset Program (TOP) 60-Day Notice, to a debtor identifying the amount the department intends to refer to TOP for offset.

11.5(4) *Offset fee.* For each offset that the Treasury Department effects against an individual referred to TOP, Treasury will charge the individual a fee.

11.5(5) *Appeal rights.* When an individual wishes to contest the delinquent status of a claim as identified by DIA, a written request shall be submitted to DIA within 60 days of the date of the pre-offset notice. When the request is received within the 60-day limit, a review shall be granted.

DIA shall determine if the claim is past due and legally enforceable and shall notify the individual in writing of the decision.

11.5(6) *Application of setoff.* DIA shall apply any setoff received as a result of this rule to the individual's food assistance debts.

Any amount remaining after the setoff shall be released back to the individual.

These rules are intended to implement Iowa Code sections 217.34, 234.12, 239B.14, and 249A.5.

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CHAPTER 12
VOLUNTEER SERVICES
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The department of human services' volunteer program is designed as a method of enhancing services provided to Iowans who reside in state institutions and to those who experience personal economic and social problems in order to relieve their constraining conditions and develop and enhance their individual productivity and family life.

Examples of roles volunteers assume include parent aides, friendly visitors, commodity distributors, clerical assistants, and medical transporters. The program allows services to be delivered in a manner most appropriate for individual counties and institutions, recognizing that the needs for volunteer services vary from county to county and from institution to institution.

441—12.1(234) Definition. "Volunteer" means a person registered with the department who provides services to clients without wages.

441—12.2(234) Allocation of block grant funds. Volunteer services in the eight department districts are funded with federal social services block grant funds and state-appropriated funds. An equal amount of money is allocated to each district. Costs incurred in providing volunteer services to the department's nine institutions are included in the institution's budgets and are not block grant funds.

The districts enter into administrative support contracts either with individuals or agencies to recruit volunteers to assist the department in service delivery. Rules governing these contracts are found in rule 441—150.5(234).

441—12.3(234) Requirements for volunteers.

12.3(1) Individuals wanting to become volunteers for the department must complete Form 470-0649, Volunteer Application, to apply, and Form 470-2347, Volunteer Registration, upon approval. Groups wanting to become volunteers must complete Form 470-2071, Volunteer Group Application and Registration.

12.3(2) Prospective volunteers must agree to have the references they list on the application checked by the department.

12.3(3) Volunteers must attend orientation and training for the volunteer position.

12.3(4) All volunteers must comply with the confidentiality requirements of the department. Breach of confidentiality is a violation of the criminal law and reason for immediate termination as a departmental volunteer.

12.3(5) The volunteers are expected to adhere to the general rules and regulations in the local offices in which they may be working, such as hours of work and completing reports. Failure to comply with the rules and regulations may lead to dismissal as a volunteer.

441—12.4(234) Volunteer service programs. Programs for the use of volunteer services may be established by the district administrator, county director, and institution superintendent or their designees to broaden and strengthen the delivery of services to department clients. Volunteers may be used to supplement, but not to take the place of, personnel whose services are obtained through the usual employment procedures.

441—12.5(234) Services and benefits available to volunteers.

12.5(1) Volunteers are entitled to liability protection on the same basis as state employees under Iowa Code chapter 669.

12.5(2) Volunteers may also be provided other benefits which would be set forth in the district's volunteer contract or in the institution's volunteer handbook.

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 13
PROGRAM EVALUATION

PREAMBLE

The purpose of this chapter is to define the methods and procedures used by the department to provide a systematic method for measuring the validity of the eligibility determinations in the aid to dependent children (ADC), food stamp, and Medicaid programs; to provide a basis for establishing state agency liability for errors that exceed the national standard and state agency eligibility for enhanced funding; and to provide program information which can be used by the department in determining a corrective action plan to ensure the rules and regulations are implemented in accordance with the ADC, food stamp and Medicaid rules.

441—13.1(234,239B,249A) Definitions.

"Active case" means a case that was receiving assistance for the month of review.

"Case record" means the record used to establish a client's eligibility.

"Client" means a current or former applicant or recipient of aid to dependent children, food stamps, or Medicaid.

"Collateral contact" means a source of information which can be used to verify the client's circumstances.

"Department" means the Iowa department of human services.

"Field investigation" means a contact involving the public or other agencies to obtain information about the client's circumstances for the appropriate month of review.

"Local agency" means the local or district office of the department.

"Month of review" means the specific calendar or fiscal month for which the assistance under review is received.

"Negative case" means a case that was terminated or denied assistance for the month of review.

"Public assistance programs" means those programs involving federal funds, i.e., aid to dependent children, food stamps, Medicaid.

"Random sample" means a systematic (or every nth unit) sample drawn monthly for which each item in the universe has an equal probability of being selected. Sample size is determined by federal guidelines.

"State policies" means the rules and regulations used by the local agency to administer the aid to dependent children, food stamp, and Medicaid programs.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, and 249A.4.

441—13.2(234,239B,249A) Review of public assistance records by the department.

13.2(1) Authorized representatives of the department shall have the right to review case records to determine the following:

a. If the client has provided complete, correct and accurate information to the local agency to be used in the determination of the assistance benefits.

b. If the local agency has correctly administered the state policies in determination of assistance for the public assistance programs.

c. Whether overpayments or underpayments have been made correctly to the public assistance client during the month of review.

d. If there is indication of fraudulent practice or abuse of the public assistance programs by either the client or local agency.

13.2(2) All pertinent case records within the department may be used by the reviewer to assist in substantiating an accurate reflection as to the correctness of the assistance paid to the client.

This rule is intended to implement Iowa Code sections 234.12, 239B.4 and 249A.4.

441—13.3(234,239B,249A) Who shall be reviewed. Any active or negative public assistance case may be reviewed at any time at the discretion of the department based upon a random sample to:

13.3(1) Ensure federal and state requirements for quality control are met.

13.3(2) Detect error prone case issues to assist in corrective action.

13.3(3) Maintain public assistance program integrity.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, and 249A.4.

441—13.4(234,239B,249A) Notification of review. On positive case actions, clients shall be notified, either orally or in writing, that their case has been selected for review. The client will be contacted in a negative case only if a discrepancy exists which cannot be resolved from the case record.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, and 249A.4.

441—13.5(234,239B,249A) Review procedure. The department will select the appropriate method of conducting the review. Review procedures may include, but are not limited to, the following:

13.5(1) A random sampling of active and negative case actions shall be used to determine the case records to be studied.

13.5(2) The case record shall be analyzed for discrepancies, correct application of policies and procedures and shall be used as the basis for a field investigation.

13.5(3) Client interviews shall be required as follows:

a. Personal interviews are required on all active aid to dependent children and food stamp reviews. Form 470-1065, Appointment Confirmation, may be sent to the client requesting written confirmation of the appointment time.

b. In lieu of the personal interview, Medicaid clients or their representatives are required to provide all information requested on Form 470-1633, Medicaid Questionnaire.

c. Client contacts are only required in negative case reviews when there is a discrepancy which cannot be resolved from the case record.

13.5(4) Collateral contacts are required whenever the client is unable to furnish information needed or the reviewer needs additional information to establish the correctness of eligibility and payment. The following forms shall be used to contact the collateral source in order to verify information specified below. The collateral contact shall complete the requested information and return the form to the reviewer.

a. The client shall not be required to give written permission of the following collateral contacts:

(1) Absent Parent Questionnaire, Form 470-0457, sent to the absent parent in order to determine whether or not the absent parent had provided any income to or had any resources for the client or children which would have affected the review month.

(2) Grandparent Questionnaire, Form 470-1643, sent to the child(ren)'s grandparents to determine whether or not the grandparents had provided any income or had any resources for the client or child(ren) which would have affected the review month.

(3) Motor Vehicle Information Request, Form 470-1634, used to determine whether or not the client had any registered vehicles.

(4) Property Verification Request, Form 470-1641, used to determine whether or not the client had any recorded property.

(5) Application for Confidential Verification of Vital Statistics, Form 470-0474, used to verify birth, death, and marital status when the event took place in Iowa.

(6) Address Information Request, Form 470-0176, used to contact the post office to determine a person's mailing address.

(7) Facility Questionnaire, Form 470-0100, used in Medicaid cases to determine information concerning a client's stay in a facility.

(8) Parent Questionnaire for Foster Children, Form 470-2014, used to contact the natural parents of the foster care child to determine the resources and income of the child.

(9) Foster Parent Questionnaire, Form 470-2013, used to contact the foster parents of the foster child to determine any resources and income of the child.

(10) Child Support Verification Request, Form 470-2009, used to contact the clerk of court or the friend of court in order to determine if child support or alimony was paid.

b. The client shall be required to sign the following specified release of information forms whenever necessary to verify information essential to the determination of eligibility and payment:

(1) Household Member Questionnaire, Form 470-1630, used to obtain information concerning a client's household composition.

(2) Landlord Questionnaire, Form 470-1632, used to contact the client's landlord.

(3) Financial Institution Questionnaire, Form 470-1631, used to verify information from a financial institution.

(4) Request for School Verification, Form 470-1638, used to verify information in the child(ren)'s school records.

(5) Earned Income Verification, Form 470-1639, used to verify information concerning a client's employment.

(6) Verification of Educational Financial Aid, Form 470-1640, used to verify information from an institution of higher learning.

(7) Authorization for Release of Information, Form 470-0461, used whenever it is necessary to verify information which is not covered by a specific release in order to establish the correctness of eligibility and payment.

c. Should the client refuse to authorize the department to contact an informant to verify information that is necessary for the completion of the review, collateral contacts shall still be made through use of the general release statement contained in the:

(1) Health and Financial Support Application, Form 470-0462 or 470-0466 (Spanish);

(2) Health Services Application, Form 470-2927 or 470-2927(S);

(3) Public Assistance Eligibility Report, Form 470-0454, 470-0455, or 470-3719(S);

(4) Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);

(5) Review/Recertification Eligibility Document, Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M);

(6) Food Assistance Interim Report, Form 470-4026, 470-4026(M), or 470-4026(S).

13.5(5) On aid to dependent children and Medicaid reviews, the quality control reviewer shall seek to identify potential third-party payment resources for health services in noncasualty situations, and to identify accidents that occurred prior to or during the review month.

This rule is intended to implement Iowa Code sections 234.12, 239B.4 and 249A.4.

441—13.6(234,239B,249A) Failure to cooperate. Client cooperation with quality control is a program eligibility requirement as set forth in 441—subrule 40.7(4), paragraph *"d,"* and rules 441—65.3(234) and 441—76.8(249A). When quality control determines that the client has refused to cooperate with the review process, the client is no longer eligible for the program benefits and will not be eligible for the program benefits until the client has cooperated.

This rule is intended to implement Iowa Code sections 234.12, 239B.4 and 249A.4.

441—13.7(234,239B,249A) Report of findings. The quality control review findings are utilized by the department in the following ways:

13.7(1) The local agency will use the findings in taking the appropriate case actions where an overpayment or underpayment has been found in a client's case record.

13.7(2) The department will use the overall findings to identify error prone program issues to be used in planning their corrective action plan.

13.7(3) The department will use the findings of the overall sample period to determine the error rate used to establish state agency liability or enhanced funding.

This rule is intended to implement Iowa Code sections 234.12, 239B.4 and 249A.4.

441—13.8(234,239B,249A) Federal rereview. A sample of the cases selected by the department for review will also be reviewed by the applicable federal agency to determine the correctness of the department's review of the case.

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CHAPTER 14
OFFSET OF COUNTY DEBTS OWED DEPARTMENT

PREAMBLE

These rules provide a process for the department (1) to identify counties that owe liabilities to the department and (2) to cooperate with the department of administrative services for offsetting the counties' claims against state agencies with the liabilities which those counties owe the department. The process for identifying counties that owe liabilities and the process for offset each include notice and opportunity to be heard.

441—14.1(217,234) Definitions.

"Department" means the Iowa department of human services.

"Director" is the director of the Iowa department of human services.

"Liability" or *"debt"* means any liquidated sum due and owing to the department which has accrued through contract, subrogation, tort, operation of law, or any legal theory regardless of whether there is an outstanding judgment for that sum. Before setoff, the amount of a county's liability to the department shall be at least $50.

"Offset" shall mean to set off or compensate the department which has a legal claim against a county where there exists a county's valid claim on a state agency that is in the form of a liquidated sum due, owing and payable. Before setoff, the amount of a county's claims on a state agency shall be at least $50. The offset process shall not begin until the department has responded in writing to the county's request to resolve the unpaid bill.

441—14.2(217,234) Identifying counties with liabilities.

14.2(1) *Notice to county regarding liability.* When a bill to the county remains unpaid 60 calendar days following the date of the bill, the county shall be given written notice by the department. This notice shall:

a. State the amount due, the name of the patient or client, and the dates of service.

b. State the department's intent to use the offset program as provided in department of administrative services rules 11—Chapter 40.

c. Require the county to send a written request for review to the division of fiscal management within 30 calendar days of the date of notification if the county disputes the bill.

14.2(2) *Request for administrative review.* The county may request an administrative review by providing to the division of fiscal management within 30 calendar days of the date of the notice of liability a written response that states why the county disagrees with the amount owed. The county shall provide any relevant legal citations, client identifiers, and any additional information supporting the county's position.

14.2(3) *Administrative review.* The division of fiscal management shall review within 30 calendar days of receipt of the written request the basis for the bill and the county's position as stated in the written request for review. The division of fiscal management shall notify the county of the findings of the review in writing within 30 days of receipt of the written request.

a. The division shall make the necessary adjustments to subsequent billings sent to the county when the division agrees with the county's position regarding the liability and shall so notify the county.

b. Any further disputes concerning the amount due shall be addressed when the offset notice is issued pursuant to rule 441—14.4(217,234).

441—14.3(217,234) List of counties with amounts owed.

14.3(1) *Notification to department of administrative services.* The division of fiscal management shall provide to the department of administrative services a list of the counties with amounts owed as established through rule 441—14.2(217,234). This list shall be maintained by the department of administrative services in a liability file.

14.3(2) *Notification of change.* The division of fiscal management shall notify the department of administrative services of any change in the status of a debt in the liability file within 30 calendar days from the occurrence of the change.

14.3(3) *Certification of file.* The division of fiscal management shall certify the file to the department of administrative services semiannually in a manner prescribed by the department of administrative services.

441—14.4(217,234) Notification to county regarding offset.

14.4(1) *Notice.* The division of fiscal management shall send notification to the county within ten calendar days from the date the department of administrative services notifies the division of a potential offset. This notification shall include:

a. The department's right to the payment in question.

b. The department's right to recover the payment through this offset procedure.

c. The basis of the department's case in regard to the debt.

d. The right of the county to request the split of the payment between parties when the payment in question is jointly owned or otherwise owned by two or more persons.

e. The county's right to appeal the offset pursuant to 441—Chapter 7.

(1) and (2) Rescinded IAB 8/7/02, effective 9/11/02.

f. Rescinded IAB 2/5/03, effective 2/1/03.

g. The telephone number for the county to contact in the case of questions.

14.4(2) *Copy of notice.* The department of administrative services may require a copy of this notice be sent to it.

14.4(3) *Appeal request.*

a. The county shall have 30 days to request an appeal. The county shall waive any right to appeal if the county fails to respond within 30 calendar days of the date of the notification.

b. The request for appeal should include any relevant legal citations and any additional information supporting the county's position. If the county believes it has provided all relevant information as a part of the disputed-billing process, the county may instead note that the department already has the relevant information.

c. The county's request for appeal shall suspend the offset action until a final appeal decision is issued.

441—14.5(217,234) Implementing the final decision. When the final decision issued pursuant to rule 441—7.16(17A) upholds the department's action or modifies the amount of offset, the division of fiscal management shall certify to the department of administrative services that the requirements for offset under Iowa Code section 8A.504 have been met. When the final decision reverses the department's action, the division of fiscal management shall notify the department of administrative services to release the offset.

14.5(1) and **14.5(2)** Rescinded IAB 8/7/02, effective 9/11/02.

441—14.6(217,234) Offset completed.

14.6(1) *Offset implemented.* The department of administrative services shall make the offset as prescribed in rule 11—40.7(8A).

14.6(2) *Notification to county.* Once the offset has been completed, the division of fiscal management shall notify the county of the action taken along with the balance, if any, still due to the department.

14.6(3) *Duty of the department.* The department shall pay to the county any payment offset by the department of administrative services to which the department is not entitled, in accordance with established procedures.

These rules are intended to implement Iowa Code sections 217.6 and 234.6.

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[Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]

[1] Effective date of amendments to 14.2 to 14.6 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002.

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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TITLE II
Reserved

TITLE II
Reserved

CHAPTERS 16 to 21
Reserved

TITLE III
MENTAL HEALTH

CHAPTER 22
AUTISM SUPPORT PROGRAM

PREAMBLE

These rules provide for definitions of diagnostic and financial eligibility, provider qualifications, and appeal procedures related to the autism support program created in 2013 Iowa Acts, Senate File 446, division XVII. The purpose of the autism support program is to provide funding for applied behavioral analysis services and care coordination for children with a diagnosis of autism who meet certain financial and clinical eligibility criteria.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.1(225D) Definitions.

"Administrator" means the entity selected by the department through a request for proposal process or other contractual arrangement to administer the autism support program.

"Applicant" means an individual on whose behalf an application has been submitted but who has not been identified as an eligible individual, or an individual who has received a denial of eligibility for the program.

"Applied behavioral analysis" or *"ABA"* means the same as defined in Iowa Code section 225D.1.

"Autism" means autism spectrum disorders as defined in Iowa Code section 514C.28.

"Autism service provider" means a person providing applied behavioral analysis, who meets the following criteria:

1. Is certified as a behavior analyst by the Behavior Analyst Certification Board or is a health professional licensed under Iowa Code chapter 147.
2. Is approved as a member of the provider network by the department.

"Autism support fund" or *"fund"* means the autism support fund created in Iowa Code section 225D.2.

"Autism support program" or *"program"* means the program created in Iowa Code section 225D.2 to provide funding for applied behavioral analysis and care coordination for eligible individuals with a diagnosis of autism.

"Clinically relevant" means medically necessary and resulting in the development, maintenance, or restoration, to the maximum extent practicable, of the functioning of an individual.

"Department" means the department of human services.

"Diagnostic assessment of autism" means medically necessary assessment, evaluations, or tests performed by a licensed child psychiatrist, developmental pediatrician, or clinical psychologist.

"Eligible individual" means a child less than nine years of age who has been diagnosed with autism based on a diagnostic assessment of autism, is not otherwise eligible for coverage for applied behavioral analysis treatment under the medical assistance program, Iowa Code section 514C.28, or private insurance coverage, and whose household income does not exceed 400 percent of the federal poverty level.

"Federal poverty level" means the most recently revised poverty income guidelines published by the United States Department of Health and Human Services.

"Household income" means household income as determined using the modified adjusted gross income methodology pursuant to Section 2002 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

"Integrated health home" means the same as defined in 441—subrule 78.53(1).

"Maximum amount of treatment" means a maximum of 24 months of applied behavioral analysis funded by the autism support program. Months of service are not required to be consecutive.

"Maximum annual benefit" means a maximum annual benefit amount of $36,000 per year for autism support program services for an eligible individual. For the purposes of this program, the annual benefit is calculated by using as a starting date the date the first service is reimbursed by the program and an

ending date 12 months from the starting date. Expenditures included in the calculation of the maximum annual benefit include reimbursements to autism service providers for provision of applied behavioral analysis and reimbursements to integrated health homes for costs of care coordination. Cost-sharing paid by the eligible individual is not included in the calculation of the individual's annual benefit.

"Medical assistance" or *"Medicaid"* means assistance provided under the medical assistance program pursuant to Iowa Code chapter 249A and Title XIX of the Social Security Act.

"Month of service" means any month in which an individual receives at least one billable unit of applied behavioral analysis service funded by the autism support program.

"Provider network" means a network of autism service providers approved by the department to provide services to eligible individuals through the autism support program.

"Regional autism assistance program" or *"RAP"* means the regional autism assistance program created in Iowa Code section 256.35.

"Treatment plan" means a plan for the treatment of autism developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in consultation with the patient and the patient's representative.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.2(225D) Eligibility and application requirements. To be determined eligible for funding for services through the autism support program, an individual must meet the following requirements:

22.2(1) An individual shall submit an application to the administrator of the program using a standardized application form available through the administrator's and the department's Web sites, members of the provider network, the regional autism assistance program, and advocacy organizations.

22.2(2) An applicant for autism program services shall be less than the age of nine at the time of application for the program. Proof of age must be provided at the time of application. An individual who reaches the age of nine prior to receipt of the maximum benefits of the program may continue to receive services from the program in accordance with the individual's treatment plan, up to a maximum of 24 months of applied behavioral analysis treatment.

22.2(3) An individual shall have a diagnosis of autism based on a diagnostic assessment of autism dated 24 months or less from the date of application for the program.

22.2(4) An individual shall be determined ineligible for coverage of applied behavioral analysis services under the medical assistance program, Iowa Code section 514C.28, or private insurance coverage. Proof of insurance coverage and noneligibility for coverage for applied behavioral analysis shall be provided at the time of application.

22.2(5) An individual shall have a household income equal to or less than 400 percent of the federal poverty level. Information needed to determine household income using modified adjusted gross income methodology shall be identified on the program application. The information shall be provided at the time of application.

22.2(6) The administrator shall provide to the parent or guardian a written notice of decision determining initial eligibility or denial within 30 calendar days of receipt of the application.

22.2(7) The administrator shall refer an applicant determined to be an eligible individual to care coordination services. The referral will occur within 5 business days of determination of eligibility for the program. Care coordination services will be provided by the University of Iowa regional autism assistance program (RAP) or an integrated health home. Eligible individuals who reside in counties where integrated health homes for children with a serious emotional disturbance are operational may choose to receive care coordination through the University of Iowa RAP program or an integrated health home that serves residents of the eligible individual's county of residence. Care coordination is not required as a condition of receiving services through the autism support program.

22.2(8) For individuals determined eligible for the program but unable to access services due to lack of available providers, the administrator shall maintain a list of such individuals and shall work to connect eligible individuals on the list to network providers.

22.2(9) The administrator shall stop processing applications at the point where available funds are fully obligated for eligible individuals and additional eligible individuals would cause expenditures in

excess of the funds available to the program. The administrator shall maintain a waiting list of individuals denied access to the program due to lack of available funds. If additional funds become available, the administrator shall contact individuals on the list in order of the earliest date and time of the receipt of the original application. The applicant shall be allowed 30 calendar days to submit an updated application and any required information needed to determine eligibility. If the applicant does not submit required information, the applicant will be denied eligibility and removed from the waiting list maintained for individuals denied access to the program due to lack of funding. The age of the applicant at the time of the most recent application will be used when determining eligibility for the program.
[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.3(225D) Cost-sharing requirements and graduated schedule of cost sharing.

22.3(1) An individual with a household income equal to or greater than 200 percent of the federal poverty level, up to a maximum of 400 percent of the federal poverty level, shall be subject to cost-sharing requirements. Cost sharing shall be implemented incrementally up to a maximum of 10 percent of the costs of the services provided through the program for an individual with a household income equal to 400 percent of the federal poverty level. The following is a chart of the cost-sharing requirements:

Family income as a % of FPL	% of cost-sharing of service costs	Family income as a % of FPL	% of cost-sharing of service costs
200%	.476%	310%	5.712%
210%	.952%	320%	6.188%
220%	1.428%	330%	6.664%
230%	1.904%	340%	7.14%
240%	2.38%	350%	7.616%
250%	2.856%	360%	8.092%
260%	3.332%	370%	8.568%
270%	3.808%	380%	9.04%
280%	4.284%	390%	9.516%
290%	4.76%	400%	9.992%
300%	5.236%		

22.3(2) An individual may request an exemption from cost sharing due to financial hardship. To qualify for an exemption, an individual shall submit written documentation to the administrator that the individual or the individual's family does not have the financial means to fulfill cost-sharing requirements.

22.3(3) Criteria to determine financial hardship include, but are not limited to, a change in income, change in employment of the parent or guardian, additional medical expenditures, other family members' health conditions, or other conditions which may affect the ability to fulfill cost-sharing requirements. The administrator shall provide a written determination regarding eligibility for exemption from cost-sharing requirements. Eligibility for exemption from cost sharing expires at the end of the financial eligibility period.
[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.4(225D) Review of financial eligibility, cost-sharing requirements, exemption from cost sharing, and disenrollment in the program.

22.4(1) An eligible individual's continued financial eligibility for the program, cost-sharing requirements, and exemption from cost sharing shall be determined on an annual basis.

22.4(2) The administrator shall request needed information from the eligible individual's parent or guardian for redetermination of financial eligibility, cost-sharing requirements, and exemption from cost sharing at least 30 days prior to the expiration of the eligible individual's eligibility period. The notice

requesting information needed for renewal of eligibility shall include the ending date of eligibility for services.

22.4(3) The administrator shall provide a written notice of decision determining ongoing eligibility or denial within 15 calendar days of receipt of the continued financial eligibility documentation.

22.4(4) If the signed application and verification of continuing eligibility are not received by the administrator by the last working day of the renewal month, the individual's eligibility for the program shall be terminated.

22.4(5) Reasons for disenrollment in the autism support program include:

a. Death of the eligible individual.

b. The family no longer meets one or more of the eligibility criteria outlined in rule 441—22.2(225D).

c. The parent or legal guardian has failed to provide information required for redetermination of eligibility.

d. The eligible individual has failed to access authorized services for a period of three consecutive months and has not made arrangements with the autism service provider or administrator to access authorized services.

e. No funds are appropriated for the autism support program.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.5(225D) Initial service authorization and renewal of service authorization.

22.5(1) All services reimbursed through the program shall be prior-authorized by the administrator.

22.5(2) An autism service provider shall submit an initial treatment plan to the administrator specifying a plan of treatment for a period of no more than six months. The initial treatment plan shall specify the amount of units of applied behavioral analysis services requested for the eligible individual and include a baseline standardized assessment score.

22.5(3) Family engagement and participation are required for participation in the autism support program. Treatment plans shall identify specific activities and responsibilities of parents or guardians in the treatment plan.

22.5(4) The treatment plan shall reflect the autism service provider's engagement with the school in which the eligible individual is enrolled. Treatment plans shall identify specific actions taken by the autism service provider to engage the eligible individual's school and the results of such actions.

22.5(5) The treatment plan may include services provided by staff with a minimum of a bachelor's degree in a human services or education field, working under the supervision of an autism service provider who is board-certified as a behavior analyst. The treatment plan shall identify which services shall be provided directly by the autism service provider and which services shall be provided by staff under the supervision of the autism service provider.

22.5(6) For renewal or modification of service authorizations, the autism service provider shall submit an updated plan of treatment with a request for the number of units of applied behavioral analysis the provider believes is medically necessary to address the eligible individual's ongoing treatment needs. The autism service provider shall also provide evidence of the eligible individual's progress on identified treatment goals. The administrator shall consider the eligible individual's updated standardized assessment score along with other clinical information when reviewing requests for renewal or modification of service authorizations. Ongoing service authorization requests shall not exceed six months in duration.

22.5(7) The administrator shall provide approval, request for modification, or denial within five business days of receipt of all service authorization requests.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.6(225D) Provider network. The administrator shall establish and maintain a network of department-approved autism service providers so that applied behavioral analysis services are available to eligible individuals statewide to the maximum extent possible.

22.6(1) A provider shall be approved to participate in the autism support program provider network if the provider meets one of the following standards in paragraph 22.6(1)*"a," "b"* or *"c"*:

a. The autism service provider is certified as a behavior analyst by the Behavior Analyst Certification Board; or

b. The autism service provider is a health professional licensed under Iowa Code chapter 147. A health professional licensed under Iowa Code chapter 147 who does not hold a current certification as a board-certified behavior analyst shall provide evidence of training in applied behavioral analysis and be licensed as a mental health professional under Iowa Code section 228.1(6); or

c. A provider shall be deemed eligible to participate in the autism support program provider network if the autism service provider meets the standards in paragraph 22.6(1)*"a"* or *"b"* and the provider is approved to provide applied behavioral analysis services through Medicaid.

22.6(2) The administrator's provider network shall accept the rate established by the department through the department's contract with the administrator as payment in full for the services rendered and will not charge eligible individuals any additional fees for services rendered, except for those eligible individuals who are required to pay a portion of the cost of services due to cost-sharing requirements.

22.6(3) The administrator is responsible for calculating the cost-sharing amount according to standards established in this chapter.

22.6(4) The autism service provider is responsible for collecting the cost-sharing amount from the eligible individual and will only be reimbursed by the administrator for the balance of the service fee minus the amount of cost sharing.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.7(225D) Financial management of the program. The autism support program administrator shall:

1. Not take new applications for the program that would cause expenditures of the program to exceed the budgeted amount.

2. Limit expenditure of program funds to services for those individuals determined to be eligible individuals and for related administrative costs.

3. Limit annual expenditures for each eligible individual to the amount identified in Iowa Code section 225D.2(2)*"a."*

4. Limit length of service through the program to the amount identified in Iowa Code section 225D.2(2)*"b."*

5. Allocate available funds for eligible individuals' services in a manner that allows for funding for all eligible individuals' services authorized by the administrator without exceeding the department's funding limits.

6. Limit payment for applied behavioral analysis services to an hourly or equivalent quarter-hour unit rate that is equal to the contracted rate currently paid by Medicaid for applied behavioral analysis services.

7. Limit payment for integrated health home services to an amount consistent with the monthly per-member per-month amount paid by Medicaid to approved providers of integrated health home services for children with a serious emotional disturbance.

8. Not provide financial compensation to the University of Iowa regional autism assistance program for care coordination services.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

441—22.8(225D) Appeal. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7.

[**ARC 1329C**, IAB 2/19/14, effective 4/1/14]

These rules are intended to implement Iowa Code chapter 225D.

[Filed ARC 1329C (Notice ARC 1184C, IAB 11/13/13), IAB 2/19/14, effective 4/1/14]

CHAPTER 23
MENTAL HEALTH AND DISABILITY SERVICES REDESIGN TRANSITION FUND

PREAMBLE

This chapter provides rules for gathering information and guiding the development of recommendations to the governor and legislature for the mental health and disability services transition fund for state fiscal year 2013.

441—23.1(225C,84GA,SF2315) Definitions.

"Commission" or *"MHDS commission"* means the mental health and disability services commission.

"County-operated program" means services directly provided by county employees.

"Current core county mental health and disability services" means those services defined in the county management plan approved by the commission and effective as of June 30, 2012.

"Department" means the Iowa department of human services.

"Documentation information and materials" means source documents, worksheets, notes, or any written material used in completing the application for transition funds.

"Independently verified" means a signed written opinion of accuracy and reasonableness of financial information submitted in the application by the county auditor based on a review and verification of the documentation information and materials used to complete the application.

"Subsidize" means that the county provides additional funding for county-operated services over and above amounts reimbursed from third-party payers, including Medicaid or Medicare, or costs in excess of usual and customary charges for the service.

"Sustainability plan" means financial estimates and a description of estimates and assumptions used to ensure that services requested to be funded by the transition fund can and will continue when the transition fund is discontinued at the end of state fiscal year 2013.

"Target population" means an adult diagnosed with a mental illness as defined in Iowa Code section 4.1(21A) or an individual with an intellectual disability as defined in Iowa Code section 4.1(9A).

"Transition fund" means the mental health and disability services redesign transition fund that has been established pursuant to 2012 Iowa Acts, Senate File 2315, section 23, and, once funds have been appropriated, will provide one-time assistance in state fiscal year 2013 to support county continuation of current core county mental health and disability services to target populations not funded by Medicaid.

[**ARC 0346C**, IAB 10/3/12, effective 9/11/12; **ARC 0573C**, IAB 2/6/13, effective 4/1/13]

441—23.2(225C,84GA,SF2315) Eligibility. A county is eligible for one-time transition funds in state fiscal year 2013, once transition funds are appropriated, if the county meets the following eligibility requirements. Each county shall:

1. Demonstrate that the county levy certified for its services fund under Iowa Code section 331.424A for state fiscal year 2013 is the maximum amount authorized by law.
2. Demonstrate that the county's projected expenditures for state fiscal year 2013, excluding increased costs for county administration and subsidies for county-operated programs, are in excess of the county's projected available funds for state fiscal year 2013.
3. Demonstrate that a reduction in the amount, scope, and duration of current core county mental health and disability services is necessary in the absence of transition funding.
4. Submit an application that meets the application requirements.

[**ARC 0346C**, IAB 10/3/12, effective 9/11/12; **ARC 0573C**, IAB 2/6/13, effective 4/1/13]

441—23.3(225C,84GA,SF2315) Application requirements. All of the following requirements must be met for a county to be eligible for transition funds.

23.3(1) The application must be:

a. Submitted using Form 470-5125, MHDS Transition Fund Application, prescribed by the department.

b. Completed with all forms and information.

c. Signed by the chairperson of the county board of supervisors, county auditor, and central point of coordination administrator.

d. Verified independently by the county auditor.

e. Delivered no later than 4:30 p.m. on November 1, 2012.

23.3(2) The application for transition funds must include the following current core county mental health and disability services information:

a. County eligibility criteria for an individual to receive county mental health and disability services.

b. A copy of the copay and sliding fee schedule as established in the county management plan.

c. A complete list of fees and copays that the county charges for each service provided.

d. The number of individuals who received non-Medicaid-funded services paid for by the county in state fiscal year 2012.

e. The projected number of individuals who will receive non-Medicaid-funded services paid by the county in state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

23.3(3) The application for transition funds shall include actual unaudited county financial information for state fiscal year 2012 and projected county financial information for state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015 reported on a cash basis.

a. Financial information regarding available funds.

(1) Amount of funds carried forward from the previous state fiscal year excluding any amount received from the risk pool in state fiscal year 2012.

(2) Amount of county funding levied and how amount of county funding levied compares with the maximum amount authorized by law.

(3) Amount of state fiscal year 2012 risk pool funds awarded to the county listed by the state fiscal year in which risk pool funds were or will be used, including an explanation of any amounts of state fiscal year 2012 risk pool funds that are projected to be returned.

(4) Amount of funding received in state fiscal year 2012 through the state payment program for non-Medicaid-funded services for individuals for whom legal settlement has not been determined, including this same amount for projected state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

b. Financial information regarding expenditures.

(1) Amount for county administrative costs, excluding administrative costs of county-operated programs, determined using cost allocation methods consistent with principles contained in OMB Circular A-87.

(2) Total amount needed to pay for expenses due and owing that were incurred in previous state fiscal years including, but not limited to:

1. County administrative costs.

2. Provider payments including the cost of services for county-operated programs and excluding any costs that subsidize county-operated programs.

3. State charges for the cost of services listed by the state fiscal year in which the charge was incurred:

- Including the county's portion of the nonfederal share of Medicaid.
- Including the county's share of mental health institutes and state resource centers minus credits.
- Excluding any state charges that will be forgiven consistent with 2012 Iowa Acts, Senate File 2315, section 27.

(3) Amount paid to private service providers for non-Medicaid-funded services.

(4) Amount paid for non-Medicaid-funded county-operated programs including an allocation of administrative costs for such services consistent with principles contained in OMB Circular A-87 and excluding any amounts to subsidize county-operated programs.

(5) Service expenditures reported in subparagraphs 23.3(3)*"b"*(3) and (4) above shall be divided into the following eligibility categories:

1. Individuals in the target population whose income is equal to or less than 150 percent of the federal poverty level.

2. Individuals in the target population whose income is greater than 150 percent of the federal poverty level.

3. Individuals with a disability other than the target population whose income is equal to or less than 150 percent of the federal poverty level.

4. Individuals with a disability other than the target population whose income is greater than 150 percent of the federal poverty level.

c. The county shall retain the county's documentation information and materials used to complete the application for transition funding and shall have this documentation information and materials available for review by the department or its designee.

23.3(4) For a county to be considered for transition funds, it must submit a sustainability plan that includes projected expenditures for state fiscal year 2014 and state fiscal year 2015 and a justification for the projections including:

a. A description of the facts and assumptions used when estimating revenues and expenditures for state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

b. Identification of key steps that will be taken to ensure that the level of current core county mental health and disability services continues beyond state fiscal year 2013.

c. An explanation of how the requested moneys will be used during the transition year to provide services in a manner that shall enable the county to continue to provide services at current levels in future years within the amount of funding the county has available.

[**ARC 0346C**, IAB 10/3/12, effective 9/11/12; **ARC 0573C**, IAB 2/6/13, effective 4/1/13]

441—23.4(225C,84GA,SF2315) Guidelines for the management of transition funds. This rule establishes guidelines for the department for the receiving, analyzing, recommending, and reporting of transition fund applications.

23.4(1) The department shall provide each county's central point of coordination administrator and the county board of supervisors a set of rules for transition funds and a copy of the application form to be used for applying for transition funds.

23.4(2) The department shall only accept county applications that are complete, submitted on the required forms, properly signed, independently verified, and received by the department by 4:30 p.m. on November 1, 2012.

23.4(3) The department shall develop a recommendation regarding the amount of transition funding the county should receive to continue the current core county mental health and disability services. The department's recommendation shall:

a. Exclude projected costs that reflect an increase in the amount, scope, or duration of services above that provided in state fiscal year 2012 based on an analysis of the number of individuals served and the cost per individual in state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

b. Exclude increased costs of county administration above that expended in state fiscal year 2012.

c. Include recommendations for adjustments based on a review of the county's documentation information and materials.

d. Include costs of current core county mental health and disability services that are in excess of available funds, excluding the costs as shown in paragraphs 23.4(3)*"a"* and *"b"* above.

23.4(4) The department's report to the governor and the legislature on December 1, 2012, shall include:

a. The names of counties that applied for transition funds.

b. The department's recommendation of the amount that the county shall receive to continue current core county mental health and disability services in state fiscal year 2013.

c. The department's opinion regarding whether or not the county has a viable sustainability plan.

[**ARC 0346C**, IAB 10/3/12, effective 9/11/12; **ARC 0573C**, IAB 2/6/13, effective 4/1/13]

441—23.5(225C,84GA,SF2315) Allocation of transition funds. The department shall allocate funds to eligible counties consistent with legislative appropriations. If the amount appropriated by the legislature for transition funds is insufficient to provide for the full cost recommended by the department, and the legislation does not state anything to the contrary, the department shall distribute funds based on the following priorities:

1. Individuals in the target population whose income is equal to or less than 150 percent of the federal poverty level.
2. Individuals in the target population whose income is greater than 150 percent of the federal poverty level.
3. Individuals with a disability other than the target population whose income is equal to or less than 150 percent of the federal poverty level.
4. Individuals with a disability other than the target population whose income is greater than 150 percent of the federal poverty level.

[**ARC 0346C**, IAB 10/3/12, effective 9/11/12; **ARC 0573C**, IAB 2/6/13, effective 4/1/13]

These rules are intended to implement Iowa Code chapter 225C and 2012 Iowa Acts, Senate File 2315, section 23, and 2012 Iowa Acts, Senate File 2336, sections 56 and 66.

[Filed Emergency ARC 0346C, IAB 10/3/12, effective 9/11/12]

[Filed ARC 0573C (Notice ARC 0348C, IAB 10/3/12), IAB 2/6/13, effective 4/1/13]

CHAPTER 24
ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES

PREAMBLE

The mental health, mental retardation, developmental disabilities, and brain injury commission has established this set of standards to be met by all providers of services to people with mental illness, mental retardation, or developmental disabilities that are under the authority of the commission. These standards apply to providers that are not required to be licensed by the department of inspections and appeals. These providers include community mental health centers, mental health services providers, case management providers, and supported community living providers, in accordance with Iowa Code chapter 225C.

The standards serve as the foundation of a performance-based review of those organizations for which the commission holds accreditation responsibility, as set forth in Iowa Code chapters 225C and 230A. The mission of accreditation is to assure individuals using the services and the general public of organizational accountability for meeting best practices performance levels, for efficient and effective management, and for the provision of quality services that result in quality outcomes for individuals using the services.

The commission's intent is to establish standards that are based on the principles of quality improvement and are designed to facilitate the provision of excellent quality services that lead to positive outcomes. The intent of these standards is to make organizations providing services responsible for effecting efficient and effective management and operational systems that enhance the involvement of individuals using the services and to establish a best practices level of performance by which to measure provider organizations.

441—24.1(225C) Definitions.

"Accreditation" means the decision made by the commission that the organization has met the applicable standards.

"Advanced registered nurse practitioner" means a nurse who has current licensure as a registered nurse in Iowa, or licensure in another state that is recognized in Iowa pursuant to Iowa Code chapter 152E, and who is also registered as certified in psychiatric mental health specialties pursuant to board of nursing rules in 655—Chapter 7.

"Advisory board" means the board that reviews and makes recommendations to the organization on the program being accredited. The advisory board shall meet at least three times a year and shall have at least three members, at least 51 percent of whom are not providers. The advisory board shall include representatives who have disabilities or family members of persons with disabilities. The advisory board's duties include review and recommendation of policies, development and review of the organizational plan for the program being accredited, review and recommendation of the budget for the program being accredited, and review and recommendation of the performance improvement program of the program being accredited.

"Anticipated discharge plan" means the statement of the condition or circumstances by which the individual using the service would no longer need each of the specific services accredited under this chapter.

"Appropriate" means the degree to which the services or supports or activities provided or undertaken by the organization are suitable and desirable for the needs, situation, or problems of the individual using the service.

"Assessment" means the review of the current functioning of the individual using the service in regard to the individual's situation, needs, strengths, abilities, desires and goals.

"Benchmarks" means the processes of an organization that lead to implementation of the indicators.

"Chronic mental illness" means the condition present in people aged 18 and over who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary

aspects of daily living as personal relations, living arrangements, or employment. People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).

2. They have experienced at least one episode of continuous, structured, supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, employed in a sheltered setting, or have markedly limited skills and a poor work history.

2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.

3. They show severe inability to establish or maintain a personal social support system.

4. They require help in basic living skills.

5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

"Commission" means the mental health, mental retardation, developmental disabilities, and brain injury commission (MH/MR/DD/BI commission) as established and defined in Iowa Code section 225C.5.

"Community" means a natural setting where people live, learn, work, and socialize.

"Community mental health center" means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A.

"Crisis intervention plan" means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric, environmental, and medical emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

"Deemed status" means acceptance by the commission of accreditation or licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the division.

"Department" means the Iowa department of human services.

"Developmental disability" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. Is manifested before the age of 22;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

A person from birth to the age of nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above if the person, without services and supports, has a high probability of meeting those criteria later in life.

"Direct services" means services providing therapy, habilitation, or rehabilitation activities or support services such as transportation.

"Division" means the division of behavioral, developmental, and protective services for families, adults, and children of the department of human services.

"Doctor of medicine or osteopathic medicine" means a person who is licensed in the state of Iowa under Iowa Code chapter 148 as a physician and surgeon or under Iowa Code chapter 150A as an osteopathic physician and surgeon.

"Functional assessment" means the analysis of daily living skills. The functional assessment also takes into consideration the strengths, stated needs, and level and kind of disability of the individual using the service.

"Goal achieving" means to gain the required skills and supports to obtain the goal of choice. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Goal keeping" means assisting the individual using the service in maintaining successful and satisfying role performance to prevent the emergence of symptoms associated with role deterioration. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Incident," for the purposes of this chapter, means an occurrence involving the individual using the service that:

1. Results in a physical injury to or by the individual that requires a physician's treatment or admission to a hospital, or
2. Results in someone's death, or
3. Requires emergency mental health treatment for the individual, or
4. Requires the intervention of law enforcement, or
5. Results from any prescription medication error, or
6. Is reportable to protective services.

"Indicators" means conditions that will exist when the activity is done competently and benchmarks are achieved. Indicators also provide a means to assess the activity's effect on outcomes of services.

"Informed consent" refers to time-limited, voluntary consent. The individual using the service or the individual's legal guardian may withdraw consent at any time without risk of punitive action. "Informed consent" includes a description of the treatment and specific procedures to be followed, the intended outcome or anticipated benefits, the rationale for use, the risks of use and nonuse, and the less restrictive alternatives considered. The individual using the service or the legal guardian has the opportunity to ask questions and have them satisfactorily answered.

"Intensive psychiatric rehabilitation practitioner" means a person who has at least 60 contact hours of training in intensive psychiatric rehabilitation and either:

1. Is certified as a psychiatric rehabilitation practitioner by the United States Psychiatric Rehabilitation Association; or
2. Holds a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and has at least one year of experience in the delivery of services to the population groups that the person is hired to serve.

"Leadership" means the governing board, the chief administrative officer or executive director, managers, supervisors, and clinical leaders who participate in developing and implementing organizational policies, plans and systems.

"Marital and family therapist" means a person who is licensed under Iowa Code chapter 154D in the application of counseling techniques in the assessment and resolution of emotional conditions. This includes the alteration and establishment of attitudes and patterns of interaction relative to marriage, family life, and interpersonal relationships.

"Mental health counselor" means a person who is licensed under Iowa Code chapter 154D in counseling services involving assessment, referral, consultation, and the application of counseling, human development principles, learning theory, group dynamics, and the etiology of maladjustment and dysfunctional behavior to individuals, families, and groups.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:

1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).

2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.

These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws.

"Mental retardation" means a diagnosis of mental retardation under these rules which shall be made only when the onset of the person's condition was before the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. A psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills shall make the diagnosis. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Natural supports" means those services and supports an individual using the service identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public.

"New organization" means an entity that has never been accredited under 441—Chapter 24 or an accredited entity under 441—Chapter 24 that makes a significant change in its ownership, structure, management, or service delivery.

"Organization" means:

1. A governmental entity or an entity that meets Iowa Code requirements for a business organization as a for-profit or not-for-profit business. These entities include, but are not limited to, a business corporation under Iowa Code chapter 490 or a nonprofit corporation under Iowa Code chapter 504 that provides a service accredited pursuant to the rules in this chapter.

2. A county, consortium of counties, or the department of human services that provides or subcontracts for the provision of case management.

3. A division or unit of a larger entity, such as a unit within a hospital or parent organization.

"Organization" does not include: an individual for whom a license to engage in a profession is required under Iowa Code section 147.2, any person providing a service if the person is not organized as a corporation or other business entity recognized under the Iowa Code, or an entity that provides only financial, administrative, or employment services and that does not directly provide the services accredited under this chapter.

"Outcome" means the result of the performance or nonperformance of a function or process or activity.

"Policies" means the principles and statements of intent of the organization.

"Procedures" means the steps taken to implement the policies of the organization.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for the population of a specified geographic area or for special target populations.

"Psychiatric crisis intervention plan" means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

"Psychiatric nurse" means a person who meets the requirements of a certified psychiatric nurse, is eligible for certification by the American Nursing Association, and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

"Psychiatrist" means a doctor of medicine or osteopathic medicine who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification and who is fully licensed to practice medicine in the state of Iowa.

"Psychologist" means a person who:

1. Is licensed to practice psychology in the state of Iowa or meets the requirements of eligibility for a license to practice psychology in the state of Iowa as defined in Iowa Code chapter 154B; or

2. Is certified by the Iowa department of education as a school psychologist or is eligible for certification by the Iowa department of education.

"Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

"Readiness assessment" means a process of involving the individual using the service in clarifying motivational readiness to participate in the recovery process. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Readiness development" means services designed to develop or increase an individual's interest, motivation, and resolve to engage in the rehabilitation services process, as a means of enhancing independent functioning and quality of life. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Registered nurse" means a person who is licensed to practice nursing in the state of Iowa as defined in Iowa Code chapter 152.

"Rehabilitation services" means services designed to restore, improve, or maximize the individual's optimal level of functioning, self-care, self-responsibility, independence and quality of life and to minimize impairments, disabilities and dysfunction caused by a serious and persistent mental or emotional disability.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom the individual using the service may share a residence.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with

or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless those conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means an individualized goal-oriented plan of services written in language understandable by the individual using the service and developed collaboratively by the individual and the organization.

"Staff" means people paid by the organization to perform duties and responsibilities defined in the organization's policies and procedures.

441—24.2(225C) Standards for policy and procedures.

24.2(1) *Performance benchmark.* The organization has written policy direction for the organization and each service being accredited.

24.2(2) *Performance indicators.*

a. The organization has a policies and procedures manual with policy guidelines and administrative procedures for all organizational activities and services specific to its organization that addresses the standards in effect at the time of review.

b. The policies and procedures cover each benchmark and indicator in this chapter.

c. The policies and procedures manual is made available to all staff.

441—24.3(225C) Standards for organizational activities.

24.3(1) *Performance improvement system.*

a. *Performance benchmark.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance.

b. *Performance indicators.* The organization:

(1) Annually measures and assesses organizational activities and services accredited in this chapter.

(2) Gathers information from individuals using the services, from staff, and from family members.

(3) Implements an internal review of individual records for those services accredited under this chapter. For outpatient psychotherapy and counseling services, the organization:

1. Reviews the individual's involvement in and with treatment.

2. Ensures that treatment activities are documented and are relevant to the diagnosis or presenting problem.

(4) Reviews the organization's response to incidents reported under subrule 24.4(5) for necessity, appropriateness, effectiveness and prevention. This review includes analysis of incident data at least annually to identify any patterns of risk to the health and safety of consumers.

(5) Reviews the organization's response to any situation that poses a danger or threat to staff or to individuals using the services for necessity, appropriateness, effectiveness, and prevention.

(6) Identifies areas in need of improvement.

(7) Has a plan to address the areas in need of improvement. Where applicable, the organization establishes a plan to resolve the problem of patients missing appointments.

(8) Implements the plan and documents the results.

24.3(2) *Leadership.*

a. *Performance benchmark.* Organization leaders provide the framework for the planning, designing, directing, coordination, provision and improvement of services that are responsive to the individuals using the services and the community served by the organization.

b. *Performance indicators.*

(1) There are clearly articulated mission and values statements that are reflected in the long-range organizational plans and in organization policies.

(2) The annual and long-range budgeting process involves appropriate governing and managing levels of leadership and reflects the organization's mission and values. An independent auditor or other person as provided by law performs an annual financial audit.

(3) Individuals using the services or family members of individuals using the services are represented on the organization's governing board or on an advisory board.

(4) The organization's decision-making process, including policy decisions affecting the organization, reflects involvement of the various levels of leadership and responsiveness to staff.

(5) Organization leaders solicit input from leaders of the various community groups representing individuals served by the organization in designing responsive service delivery systems.

(6) Organization leaders develop and implement a service system appropriate to the needs of the individuals served by the organization.

(7) Organization leaders make educational information, resources, and service consultation available to community groups.

24.3(3) *Management information system.*

a. Performance benchmark. Information is obtained, managed, and used in an efficient and effective method to document, enhance, and improve organizational performance and service delivery.

b. Performance indicators.

(1) The organization has a system in place to maintain current individual-specific information documenting the provision and outcomes of services and treatments provided.

(2) The organization has a system in place to maintain the confidentiality and security of information that identifies specific individuals using the services, including mail, correspondence, and electronic files.

24.3(4) *Human resources.*

a. Performance benchmark. The organization provides qualified staff to support the organization's mission and facilitate the provision of quality services.

b. Performance indicators. The organization:

(1) Has a job description in the personnel file of each staff member that clearly defines responsibilities and qualifications.

(2) Has a process to verify qualifications of staff, including degrees, licenses, medication management training, and certification as required by the position, within 90 days of the staff person's employment. For staff hired after July 1, 2006, personnel files contain evidence that verification of professional licenses and college degrees at the bachelor's level or higher, as required by the position, was obtained from the primary source.

(3) Evaluates staff annually.

(4) Includes a plan for staff development for each staff member in the annual evaluation.

(5) Provides training and education to all staff relevant to their positions.

(6) Provides for approved training on child and dependent adult abuse reporter requirements to all organization staff who are mandatory abuse reporters. The organization documents in personnel records training on child and dependent adult abuse reporter requirements.

(7) Has staff members sign a document indicating that they are aware of the organization's policy on confidentiality and maintains these documents in the personnel files.

(8) Provides an initial orientation to new staff and documents this orientation in the employee's personnel file.

(9) Has mechanisms in place that afford staff the right to express concerns about a particular care issue or to file a grievance concerning a specific employment situation.

(10) Completes criminal and abuse record checks and evaluations as required in Iowa Code section 135C.33(5) before employment for any employee who meets with individuals using the services in the individuals' homes.

(11) Establishes and implements a code of ethics for all staff addressing confidentiality, individual rights, and professional and legal issues in providing services and documents in the personnel records that the code of ethics in effect at the time of review has been reviewed with each staff member.

24.3(5) *Organizational environment.*

a. Performance benchmark. The organization provides services in an organizational environment that is safe and supportive for the individuals being served and the staff providing services.

b. Performance indicators.

(1) The environment enhances the self-image of the individual using the service and preserves the individual's dignity, privacy, and self-development.

(2) The environment is safe and accessible and meets all applicable local, state, and federal regulations.

(3) The processes that service and maintain the environment and the effectiveness of the environment are reviewed within the organization's monitoring and improvement system.

(4) The organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or others. The interventions also ensure that the individual's rights are protected and that due process is afforded.

(5) The organization meets state and federal regulations in the way it implements the safe storage, provision, administration, and disposal of medication when used within the service.

(6) All toys and other materials used by children are clean and safe.

441—24.4(225C) Standards for services. Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in subrules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8). Providers of emergency services or evaluation services shall meet the benchmark for the services they provide.

24.4(1) *Social history.*

a. Performance benchmark. The organization completes a social history for each individual served.

b. Performance indicators.

(1) The organization collects and documents relevant historical information and organizes the information in one distinct document in a narrative format.

(2) The social history includes:

1. Relevant information regarding the onset of disability.
2. Family, physical, psychosocial, behavioral, cultural, environmental, and legal history.
3. Developmental history for children.
4. Any history of substance abuse, domestic violence, or physical, emotional, or sexual abuse.

(3) Staff review and update the social history at least annually.

24.4(2) *Assessment.*

a. Performance benchmark. The organization develops a written assessment for each individual served. The assessment is the basis for the services provided to the individuals.

b. Performance indicators.

(1) The assessment includes information about the individual's current situation, diagnosis, needs, problems, wants, abilities and desired results, gathered with the individual's involvement.

(2) Staff solicit collateral provider information as appropriate to the individual situation in order to compile a comprehensive and full assessment.

(3) Staff develop and complete the assessment in a narrative format.

(4) Staff base decisions regarding the level, type and immediacy of services to be provided, or the need for further assessment or evaluation, upon the analysis of the information gathered in the assessment.

(5) Staff complete an annual reassessment for each individual using the service and document the reassessment in a written format.

(6) Documentation supporting the diagnosis is contained in the individual's record. A diagnosis of mental retardation is supported by a psychological evaluation conducted by a qualified professional. A diagnosis of developmental disability is supported by professional documentation. A determination of chronic mental illness is supported by a psychiatric or psychological evaluation conducted by a qualified professional.

24.4(3) *Individual service plan.*

a. Performance benchmark. Individualized, planned, and appropriate services are guided by an individual-specific service plan developed in collaboration with the individual using the service, staff,

and significantly involved others as appropriate. Services are planned for and directed to where the individuals live, learn, work, and socialize.

b. Performance indicators.

(1) The service plan is based on the current assessment.

(2) The service plan identifies observable or measurable individual goals and action steps to meet the goals.

(3) The service plan includes interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(4) The service plan includes the staff, people, or organizations responsible for carrying out the interventions or supports.

(5) Services defined in the service plan are appropriate to the severity level of problems and specific needs or disabilities.

(6) The plan reflects desired individual outcomes.

(7) Activities identified in the service plan encourage the ability and right of the individual using the service to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) Staff monitor the service plan with review occurring regularly. At least annually, staff assess and revise the service plan to determine achievement, continued need, or change in goals or intervention methods. The review includes the individual using the service, with the involvement of significant others as appropriate.

(9) Staff develop a separate, individualized, anticipated discharge plan as part of the service plan that is specific to each service the individual receives.

(10) The service plan includes documentation of any rights restrictions, why there is a need for the restriction, and a plan to restore those rights or a reason why a plan is not necessary or appropriate.

24.4(4) *Documentation of service provision.*

a. Performance benchmark. Individualized and appropriate intervention services and treatments are provided in ways that support the needs, desires, and goals identified in the service plan, and that respect the rights and choices of the individual using the service.

b. Performance indicators.

(1) Staff document in the narrative the individual's participation in the treatment process.

(2) Responsible staff document the individual's progress toward goals, the provision of staff intervention, and the individual's response to those interventions.

(3) Documentation of service provision is in a written, legible, narrative format in accordance with organizational policies and procedures.

24.4(5) *Incident reports.*

a. Performance benchmark. The organization completes an incident report when organization staff first become aware that an incident has occurred.

b. Performance indicators.

(1) The organization documents the following information:

1. The name of the individual served who was involved in the incident.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all organization staff and others who were present or responded at the time of the incident. (For confidentiality reasons, other individuals who receive services should be identified by initials or some other accepted means.)
5. The action the organization staff took to handle the situation.
6. The resolution of or follow-up to the incident.

(2) The staff who were directly involved at the time of the incident or who first became aware of the incident prepare and sign the incident report before forwarding it to the supervisor.

(3) Staff file a copy of the completed incident report in a centralized location and make a notation in the individual's file.

(4) Staff send a copy of the incident report to the individual's Medicaid targeted case manager or county case worker who is involved in funding the service and notify the individual's legal guardian within 72 hours of the incident.

24.4(6) *Confidentiality and legal status.*

a. Performance benchmark. Staff release medical and mental health information only when properly authorized.

b. Performance indicators.

(1) The organization obtains voluntary written authorization from the individual using the service, the individual's legal guardian, or other people authorized by law before releasing personal identifying information, medical records, mental health records, or any other confidential information.

(2) Staff complete voluntary written authorization forms in accordance with existing federal and state laws, rules, and regulations and maintain them in each individual file.

(3) Documentation regarding restrictions on the individual, such as guardianship, power of attorney, conservatorship, mental health commitments, or other court orders, is placed in the individual's record, if applicable.

24.4(7) *Service systems.*

a. Performance benchmark. The organization develops a clear description of each of the services offered. The organization develops an admission and discharge system of services. Staff coordinate services with other settings and providers.

b. Performance indicators.

(1) The organization has established and documented the necessary admission information to determine each individual's eligibility for participation in the service.

(2) Staff include verification in each individual's file that a service description was provided to the individual using the service and, when appropriate, to family or significant others.

(3) Continuity of services occurs through coordination among the staff and professionals providing services. Coordination of services through linkages with other settings and providers has occurred, as appropriate.

(4) Staff include a written discharge summary in each individual record at the time of discharge.

24.4(8) *Respect for individual rights.*

a. Performance benchmark. Each individual using the service is recognized and respected in the provision of services, in accordance with basic human, civil, and statutory rights.

b. Performance indicators.

(1) Staff provide services in ways that respect and enhance the individual's sense of autonomy, privacy, dignity, self-esteem, and involvement in the individual's own treatment. Staff take language barriers, cultural differences, and cognitive deficits into consideration and make provisions to facilitate meaningful individual participation.

(2) Staff inform individuals using the service and, when appropriate, family and significant others of their rights, choices, and responsibilities.

(3) The organization has a procedure established to protect the individuals using the service during any activities, procedure or research that requires informed consent.

(4) The organization verifies that individuals using the service and their guardians are informed of the process to express questions, concerns, complaints, or grievances about any aspect of the individual's service, including the appeal process.

(5) The organization provides the individuals and their guardians the right to appeal the application of policies, procedures, or any staff action that affects the individual using the service. The organization has established written appeal procedures and a method to ensure that the procedures and appeal process are available to individuals using the service.

(6) All individuals using the service, their legal representatives, and other people authorized by law have access to the records of the individual using the service in accordance with state and federal laws and regulations.

24.4(9) *Case management services.* "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

24.4(10) *Day treatment services.* "Day treatment" means an individualized service emphasizing mental health treatment and intensive psychosocial rehabilitation activities designed to increase the individual's ability to function independently or facilitate transition from residential placement. Staff use individual and group treatment and rehabilitation services based on individual needs and identified behavioral or mental health issues.

a. Performance benchmark. Individuals using the service who are experiencing a significantly reduced ability to function in the community are stabilized and improved by the receipt of psychosocial rehabilitation, mental health treatment services, and in-home support services, and the need for residential or inpatient placement is alleviated.

b. Performance indicators.

(1) Individuals using the service participate with the organizational staff in identifying the problem areas to be addressed and the goals to be achieved that are based on the individual's need for services.

(2) Individuals using the service receive individualized services designed to focus on those identified mental health or behavioral issues that are causing significant impairment in their day-to-day functioning.

(3) Individuals who receive intensive outpatient and day treatment services receive a comprehensive and integrated schedule of recognized individual and group treatment and rehabilitation services.

(4) Individuals using the service and staff review their progress in resolving problems and achieving goals on a frequent and regular basis.

(5) Individuals using the service receive services appropriate to defined needs and current risk factors.

(6) Individuals using the service receive services from staff who are appropriately qualified and trained to provide the range and intensity of services required by the individual's specific problems

or disabilities. A mental health professional provides or directly supervises the provision of treatment services.

(7) Individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, and community and organization resources.

(8) Family members of individuals using the service are involved in the planning and provision of services, as appropriate and as desired by the individual.

(9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(11) *Intensive psychiatric rehabilitation services.* "Intensive psychiatric rehabilitation services" means services designed to restore, improve, or maximize level of functioning, self-care, responsibility, independence, and quality of life; to minimize impairments, disabilities, and disadvantages of people who have a disabling mental illness; and to prevent or reduce the need for services in a hospital or residential setting. Services focus on improving personal capabilities while reducing the harmful effects of psychiatric disability, resulting in an individual's recovering the ability to perform a valued role in society.

a. Performance benchmark. Individuals using the service who are experiencing a significantly reduced ability to function in the community due to a disability are stabilized and experience role recovery by the receipt of intensive psychiatric rehabilitation services.

b. Performance indicators.

(1) Individuals using the service receive services from staff who meet the definition of intensive psychiatric rehabilitation practitioner. The intensive psychiatric rehabilitation supervisor has at least a bachelor's degree in a human services field and 60 hours of training in intensive psychiatric rehabilitation.

(2) Individuals using the service receive four to ten hours per week of recognized psychiatric rehabilitation services. All services are provided for an identified period.

(3) Whenever possible, intensive psychiatric rehabilitative services are provided in natural settings where individuals using the service live, learn, work, and socialize.

(4) Significantly involved others participate in the planning and provision of services as appropriate and as desired by the individual using the service.

(5) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

(6) A readiness assessment is initially completed with staff to assist the individual in choosing a valued role and environment. The readiness assessment culminates in a score that documents the individual's motivational readiness.

(7) During the readiness development phase, staff document monthly in the individual's file changes in the individual's motivational readiness to choose valued roles and environments.

(8) During the goal-choosing phase, staff and the individual identify personal criteria, describe alternative environments, and choose the goal. These activities are documented in the individual's file.

(9) During the goal-achieving phase, the functional assessment and resource assessment are completed. Skill programming or skill teaching takes place. These activities are documented in the individual's file.

(10) During goal keeping, individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, community, and organization resources for successful community tenure and the anticipated end of psychiatric rehabilitation services. Staff document increases in skill acquisition and skill competency.

(11) Staff document any positive changes in environmental status, such as moving to a more independent living arrangement, enrolling in an education program, getting a job, or joining a community group.

(12) On an ongoing basis and at discharge, staff or the individual using the service documents the level of individual satisfaction with intensive psychiatric rehabilitation services in each individual's file.

24.4(12) *Supported community living services.* "Supported community living services" means those services provided to individuals with a mental illness, mental retardation, or developmental disability to enable them to develop supports and learn skills that will allow them to live, learn, work and socialize

in the community. Services are individualized, need- and abilities-focused, and organized according to the following components: outreach to appropriate support or treatment services; assistance and referral in meeting basic human needs; assistance in housing and living arrangements; crisis intervention and assistance; social and vocational assistance; the provision of or arrangement for personal, environmental, family, and community supports; facilitation of the individual's identification and development of natural support systems; support, assistance, and education to the individual's family and to the community; protection and advocacy; and service coordination.

These services are to be provided by organizational staff or through linkages with other resources and are intended to be provided in the individual's home or other natural community environment where the skills are learned or used. Supported community living is not part of an organized mental health support or treatment group, drop-in center, or clubhouse. Skill training groups may be one of the activities in the service plan and part of supported community living. Skill training groups cannot stand alone as a supported community living service.

a. Performance benchmark. Individuals using the service live, learn, work, and socialize in the community.

b. Performance indicators.

(1) Individuals receive services within their home and community setting where the skills are learned or used.

(2) At intake, the individuals using the service participate in a functional assessment to assist in defining areas of service need and establishing a service plan. Staff summarize the findings of the functional assessment in a narrative that describes the individual's current level of functioning in the areas of living, learning, working, and socialization. Staff review functional assessments on a regular basis to determine progress.

(3) Individuals using the service receive skill training and support services directed to enabling them to regain or attain higher levels of functioning or to maximize functioning in the current goal areas.

(4) Services are delivered on an individualized basis in the place where the individual using the service lives or works.

(5) Documentation that steps have been taken to encourage the use of natural supports and develop new ones is in the individual file.

(6) Individuals using the service participate in developing a detailed individualized crisis intervention plan that includes natural supports and self-help methods.

24.4(13) *Partial hospitalization services.* "Partial hospitalization services" means an active treatment program providing intensive group and individual clinical services within a structured therapeutic environment for individuals who are exhibiting psychiatric symptoms of sufficient severity to cause significant impairment in day-to-day functioning. Short-term outpatient crisis stabilization and rehabilitation services are provided to avert hospitalization or to transition from an acute care setting. Services are supervised and managed by a mental health professional, and psychiatric consultation is routinely available. Clinical services are provided by a mental health professional.

a. Performance benchmark. Individuals who are experiencing serious impairment in day-to-day functioning due to severe psychiatric distress are enabled to remain in their community living situation through the receipt of therapeutically intensive milieu services.

b. Performance indicators.

(1) Individuals using the service and staff mutually develop an individualized service plan that focuses on the behavioral and mental health issues and problems identified at admission. Goals are based on the individual's need for services.

(2) Individuals using the service receive clinical services that are provided and supervised by mental health professionals. A licensed and qualified psychiatrist provides psychiatric consultation and medication services.

(3) Individuals using the service receive a comprehensive schedule of active, planned, and integrated psychotherapeutic and rehabilitation services provided by qualified professional staff.

(4) Individuals using the service receive group and individual treatment services that are designed to increase their ability to function independently.

(5) Individuals using the service are involved in the development of an anticipated discharge plan that includes linkages to family, provider, and community resources and services.

(6) Individuals using the service have sufficient staff available to ensure their safety, to be responsive to crisis or individual need, and to provide active treatment services.

(7) Individuals using the service receive services commensurate with current identified risk and need factors.

(8) Support systems identified by individuals using the service are involved in the planning and provision of services and treatments as appropriate and desired by the individual using the service.

(9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(14) *Outpatient psychotherapy and counseling services.* "Outpatient psychotherapy and counseling services" means a dynamic process in which the therapist uses professional skills, knowledge and training to enable individuals using the service to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems. Psychotherapy services may be individual, group, or family, and are provided by a person meeting the criteria of a mental health professional or by a person with a master's degree or an intern working on a master's degree in a mental health field who is directly supervised by a mental health professional.

a. Performance benchmark. Individuals using the service realize and mobilize their own strengths and abilities to take control of their lives in the areas where they live, learn, work, and socialize.

b. Performance indicators.

(1) Individuals using the service are prepared for their role as partners in the therapeutic process at intake where they define their situations and evaluate those factors that affect their situations.

(2) Individuals using the service establish desired problem resolution at intake during the initial assessment.

(3) Psychiatric services other than psychopharmacological services are available from the organization as needed by the individual using the service.

(4) Psychopharmacological services are available from the organization as needed.

(5) Staff document mutually agreed-upon treatment goals during or after each session. A distinct service plan document is not required.

(6) Staff document mutually agreed-upon supports and interventions during or after each session. A distinct service plan document is not required.

(7) Staff document in the progress notes the individual's status at each visit and the reasons for continuing or discontinuing services. A distinct discharge summary document is not required.

(8) Any assignment of activities to occur between sessions is documented in the following session's documentation.

(9) Individuals using the service who have a chronic mental illness participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

(10) The record documents that the organization follows up on individuals who miss appointments.

24.4(15) *Emergency services.* "Emergency services" means crisis services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress and are available and accessible, by telephone or face-to-face, on a 24-hour basis. The clinical assessment and psychotherapeutic services are provided by a person who has training in emergency services and who is a mental health professional or has access to a mental health professional, at least by telephone.

Services may be provided by a person who holds a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing, psychiatric rehabilitation, or social work; or a person who holds a bachelor's degree in a human service discipline with five years' experience providing mental health services or human services; or a psychiatric nurse who has three years of clinical experience in mental health. A comprehensive social history is not required for this treatment.

a. Performance benchmark. Individuals using the service receive emergency services when needed that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress.

b. Performance indicators.

(1) Individuals using the service can access 24-hour emergency services by telephone or in person.

(2) Information about how to access emergency services is publicized to facilitate availability of services to individuals using the service, family members, and the public.

(3) Individuals using the service receive assessments and services from either a mental health professional or from personnel who meet the requirements above and are supervised by a mental health professional. Psychiatric consultation is available, if needed.

(4) Individuals using the service receive intervention commensurate with current identified risk factors.

(5) Significantly involved others are involved as necessary and appropriate to the situation and as desired by the individual using the service.

(6) Individuals using the service are involved in the development of postemergency service planning and resource identification and coordination.

(7) Staff document contacts in a narrative format and maintain them in a central location that will allow timely response to the problems presented by the individual using the service.

(8) Timely coordination of contacts with relevant professionals is made.

24.4(16) *Evaluation services.* "Evaluation services" means screening, diagnosis and assessment of individual and family functioning needs, abilities, and disabilities, and determining current status and functioning in the areas of living, learning, working, and socializing.

a. Performance benchmark. Individuals using the service receive comprehensive evaluation services that include screening, diagnosis, and assessment of individual or family functioning, needs and disabilities.

b. Performance indicators.

(1) Evaluations include screening, diagnosis, and assessment of individual or family functioning, needs, abilities, and disabilities.

(2) Evaluations consider the emotional, behavioral, cognitive, psychosocial, and physical information as appropriate and necessary.

(3) Evaluations includes recommendations for services and need for further evaluations.

(4) Mental health evaluations are completed by a person who meets the criteria of a mental health professional, or a person with a master's degree who is license-eligible and supervised by a mental health professional, or an intern of a master's or doctorate program who is supervised by a mental health professional.

441—24.5(225C) Accreditation. The commission shall make all decisions involving issuance, denial, or revocation of accreditation. This accreditation shall delineate all categories of service the organization is accredited to provide. Although an organization may have more than one facility or service site, the commission shall issue only one accreditation notice to the organization, except as provided in paragraph 24.5(5)*"f."*

24.5(1) *Organizations eligible for accreditation.* The commission accredits the following organizations:

a. Case management providers.

b. Community mental health centers.

c. Supported community living providers.

d. Mental health service providers.

24.5(2) *Application and renewal procedures.* An applicant for accreditation shall submit Form 470-3005, Application for Accreditation, to the Division of Behavioral, Developmental, and Protective Services, Department of Human Services, Fifth Floor, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

a. The application shall be signed by the organization's chief executive officer and the chairperson of the governing body and shall include the following information:

(1) The name and address of the applicant organization.

(2) The name and address of the chief executive officer of the applicant organization.

(3) The type of organization and specific services for which the organization is applying for accreditation.

(4) The targeted population groups for which services are to be provided, as applicable.

(5) The number of individuals in each of the targeted population groups to be served, as applicable.

(6) Other information related to the standards as requested by division staff.

b. Organizations that have received an initial 270-day accreditation and have not provided services by the end of the 270 days shall have their accreditation lapse for that specific service. This lapse of accreditation shall not be considered a denial. New applications may be submitted that include the waiting list of individuals to be served along with specific timelines of when the services will begin.

c. An organization in good standing may apply for an add-on service.

24.5(3) *Application review.* Upon receipt of an application, Form 470-3005, the division shall review the materials submitted to determine whether the application is complete and request any additional material as needed. Survey reviews shall commence only after the organization has submitted all application material.

a. For a new organization, staff may initially conduct a desk audit or on-site visit to review the organization's mission, policies, procedures, staff credentials, and program descriptions.

b. The division shall review organizational services and activities as determined by the accreditation category. This review may include audits of case records, administrative procedures, clinical practices, personnel records, performance improvement systems and documentation, and interviews with staff, individuals, boards of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

c. A team shall make an on-site visit to the organization. The division shall not be required to provide advance notice to the provider of the on-site visit for accreditation.

d. The on-site team shall consist of designated members of the division staff. At the division's discretion, the team may include provider staff of other providers, individuals, and others deemed appropriate.

e. The team shall survey the organization and the services indicated on the accreditation application in order to verify information contained in the application and ensure compliance with all applicable laws, rules, and regulations. At the time of a one-year recertification visit, the team shall review the services that did not receive three-year accreditation.

f. The team shall review case records and personnel records to see how the organization implements each of the indicators in the standards. If the documentation is not found in the records, the organization shall show, at the time the division staff is on site, documentation of how the indicator was accomplished.

g. When an organization subcontracts with agencies to provide services, on-site reviews shall be done at each subcontracting agency to determine if each agency meets all the requirements in this chapter. The accreditation is issued to the organization.

h. At the end of the survey, the team leader shall lend an exit review. Before the close of the on-site review, the organization must provide the team leader any documentation that demonstrates how the organization has met these standards for services.

i. The accreditation team leader shall send a written report of the findings to the organization within 30 working days after completion of the accreditation survey.

j. Organizations required to develop a corrective action and improvement plan pursuant to subrule 24.5(4)*"a"* shall submit the plan to the division within 30 working days after the receipt of a report issued as a result of the division's survey review. The action plan shall include specific problem areas cited, corrective actions to be implemented by the organization, dates by which each corrective measure shall be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

k. Quality assurance staff shall review and approve the corrective action and improvement plan before making an accreditation recommendation to the commission.

l. The division shall offer technical assistance to organizations applying for first-time accreditation. Following accreditation, any organization may request technical assistance from the

division to bring into conformity those areas found in noncompliance with this chapter's requirements. If multiple deficiencies are noted during a survey, the commission may also require that technical assistance be provided to an organization, as staff time permits, to assist in implementation of an organization's corrective action plan. Renewal applicants may be provided technical assistance as needed, if staff time permits.

24.5(4) *Performance outcome determinations.* There are three major areas addressed in these standards: policies and procedures, organizational activities, and services, as set forth in rules 441—24.2(225C), 24.3(225C), and 24.4(225C). Each rule contains standards, with a performance benchmark and performance indicators for each standard. Each of the applicable standards for the three areas (policy and procedures, organizational activities, and services) shall be reviewed.

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, then that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or organizational activities is not met.

b. In the overall rating, the performance rating for policy and procedures shall count as 15 percent of the total, organizational activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policy and procedures has a value of 5 out of a possible score of 15.

(2) Each of the 34 indicators for organizational activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

Service	Number of indicators	Value of each indicator
Case management	51	1.37
Day treatment	48	1.46
Intensive psychiatric rehabilitation	51	1.37
Supported community living	45	1.55
Partial hospitalization	48	1.46
Outpatient psychotherapy and counseling	35	2.00
Emergency	8	8.75
Evaluation	4	17.50

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

24.5(5) *Accreditation decisions.* The division shall prepare all documents with a final recommendation regarding accreditation to be presented at the commission meeting. The division shall mail to all commission members summary reports of the on-site service review or desk review and a final recommendation concerning accreditation on each application to be processed at the next commission meeting.

If the commission approves accreditation, Form 470-3006, Notice of Action-Approval, shall be issued which states the duration of the accreditation and the services that the organization is accredited to provide. If the commission denies or revokes accreditation, Form 470-3008, Notice of Action-Denial, shall be issued which states the reasons for the denial.

a. *Initial 270-day accreditation.* This type of accreditation may be granted to a new organization. The commission shall base the accreditation decision on a report by the division that:

(1) The organization has an approved policies and procedures manual that includes job descriptions.

(2) Staff assigned to the positions meet the qualifications in the standards and the policies and procedures of the organization.

b. Three-year accreditation. An organization or service is eligible for this type of accreditation if it has achieved an 80 percent or higher performance compliance level. The organization may be required to develop and submit a plan of corrective action and improvement that may be monitored either by written report or an on-site review.

c. One-year accreditation. An organization is eligible for this type of accreditation when multiple and substantial deficiencies exist in specific areas causing compliance levels with performance benchmarks and indicators to fall between 70 percent and 79 percent, or when previously required corrective action plans have not been implemented or completed. The organization must submit a corrective action plan to correct and improve specific deficiencies and overall levels of functioning. Quality assurance staff shall monitor this plan through on-site reviews, written reports and the provision of technical assistance.

d. Probational 180-day accreditation. An organization is eligible for probational 180-day accreditation instead of denial when the overall compliance level is from 60 to 69 percent, and pervasive and serious deficiencies exist; or when corrective action plans previously required as a result of a one-year accreditation have not been implemented or completed. The commission may downgrade organizations with a one-year or three-year accreditation to the probational 180-day accreditation when one or more complaints are founded.

All deficiencies must be corrected by the time of the follow-up on-site survey at the conclusion of the provisional period. After this survey, the organization shall meet the standards for accreditation for a one-year accreditation, or the commission shall deny accreditation.

e. Add-on service accreditation. When the on-site review of the add-on service results in a score comparable to the overall organization's score at the time of the most recent accreditation, the organization shall have the add-on accreditation date coincide with the overall accreditation date of the organization. If the add-on service on-site review results in a lower score and lower accreditation decision, division staff shall conduct another on-site review for that add-on service when the add-on service accreditation expires.

f. Special terms.

(1) When an organization subcontracts with more than one agency, the length of accreditation shall be determined individually.

(2) The accreditation period for services that have deemed status according to rule 24.6(225C) shall coincide with the period awarded by the national accrediting body or the certification for home-and community-based services.

(3) New or add-on services that meet the requirements for accreditation shall receive an initial 270-day accreditation for that individual service. The term of accreditation shall be determined individually. At the time of recertification of the new add-on service, recommendation may be made to coincide with the term of accreditation for the other services of that organization that are accredited by the commission.

(4) An organization must notify the division when there are changes in its ownership, structure, management, or service delivery.

g. Extensions. The division may grant an extension to the period of accreditation if there has been a delay in the accreditation process that is beyond the control of the organization, the division, or the commission; or the organization has requested an extension to permit the organization to prepare and obtain approval of a corrective action plan. The division shall establish the length of the extension on a case-by-case basis.

h. Denial of accreditation. An emergency commission meeting may be called to consider denial or revocation of accreditation.

(1) Accreditation shall be denied when there are pervasive and serious deficiencies that put individuals at immediate risk or when the overall compliance level falls to 59 percent or below. Under such circumstances no corrective action report shall be required.

(2) When one or more complaints are received, quality assurance staff shall complete an investigation and submit a report to the commission. If any of the complaints are substantiated and the commission determines that there is a pervasive or serious deficiency, the commission may deny accreditation.

(3) An organization whose accreditation has been denied or revoked shall not be approved for any service for at least six months from the notice of decision denying or revoking accreditation.

(4) If the organization disagrees with any action or failure to act in regard to the notice of decision to deny accreditation to the organization, the organization has the right to appeal in accordance with 441—Chapter 7.

24.5(6) *Nonassignability.* Accreditation shall not be assignable to any other organization or provider. Any person or other legal entity acquiring an accredited facility for the purpose of operating a service shall make an application as provided in subrule 24.5(2) for a new certificate of accreditation. Similarly, any organization having acquired accreditation and desiring to alter the service philosophy or transfer operations to different premises must notify the division in writing 30 calendar days before taking action in order for the division to review the change.

24.5(7) *Discontinuation.*

a. *Discontinued organization.* A discontinued organization is one that has terminated all of the services for which it has been accredited. Accreditation is not transferable between organizations.

(1) An organization shall notify the division in writing of any sale, change in business status, closure, or transfer of ownership of the business at least 30 calendar days before the action.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

b. *Discontinued service.* An organization shall notify the division in writing of the discontinuation of an accredited or certified service at least 30 calendar days before the service is discontinued.

(1) Notice of discontinuation of a service shall not be initiated during the 30 days before the start of a survey. Once a survey has begun, all services shall be considered in determining the organization's accreditation score.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

441—24.6(225C) Deemed status. The commission shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the commission determines the accreditation is for similar services. The commission may also grant deemed status for supported community living services to organizations that are certified under the Medicaid home- and community-based services (HCBS) mental retardation waiver.

24.6(1) *National accrediting bodies.*

a. The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. Council on Accreditation of Services for Families and Children (COA).

b. The accreditation credentials of these national bodies must specify the type of organization, programs, and services that these bodies accredit and include targeted population groups, if appropriate.

c. Deemed status means that the division is accepting an outside body's review, assessment, and accreditation of an organization's functioning and services. Therefore, the accrediting body doing the review must be assessing categories of organizations and types of programs and services corresponding to those described under this chapter. An organization that has deemed status must adhere to and be accountable for the rules in this chapter.

d. When an organization that is nationally accredited requests deemed status for services not covered by the national body's standards but covered under this chapter, the division shall accredit

those services. Division staff shall provide technical assistance to organizations with deemed status as time permits.

24.6(2) *Application for deemed status.*

a. To apply for deemed status, the organization shall submit Form 470-3332, Application and Letter of Agreement, and copies of the latest survey report and accreditation certificate, documentation of specific programming policies and procedures for populations being served, and credentials for staff providing services to populations served.

b. The division shall not accept an application for deemed status once the division has begun an on-site visit. The organization shall complete the accreditation process.

24.6(3) *Requirements for deemed status.* To be eligible for deemed status, the organization shall:

a. Be currently accredited by a recognized national accrediting body for services as defined in subrule 24.6(1); or

b. Be currently accredited for supported community living under the Medicaid HCBS mental retardation waiver pursuant to 441—subrule 77.37(14). If individuals with mental illness are served, the organization must submit verification of the training and credentials of the staff to show that its staff can meet the needs of the individuals served.

c. Require the supported community living staff to have the same supervisor as the HCBS/MR program.

d. Require staff for the program being deemed to have the training and credentials needed to meet the needs of the person served.

e. Require staff to meet the incident reporting requirements in subrule 24.4(5).

24.6(4) *Granting of deemed status.* When the commission grants deemed status, the accreditation period shall coincide with the period awarded by the national accrediting body or the certification for home- and community-based services. However, under no circumstances shall the commission award accreditation for longer than three years.

24.6(5) *Reservations.* When deemed status is granted, the commission and the division reserve rights to the following:

a. To have division staff conduct on-site reviews for those organizations applying for deemed status which the division has not previously accredited.

b. To have division staff do joint site visits with the accrediting body, attend exit conferences, or conduct focused follow-behind visits as determined to be appropriate in consultation with the national accrediting organization and the provider organization.

c. To be informed of and to investigate all complaints that fall under this chapter's jurisdiction according to the process in rule 441—24.7(225C). The division shall report findings to the national accrediting body.

d. To review and act upon deemed status when:

(1) Complaints have been founded, or

(2) The organization's national accreditation status expires without renewal, or

(3) The national accrediting body downgrades or withdraws the organization's status.

24.6(6) *Continuation of deemed status.*

a. The organization shall send a copy of Form 470-3332, Application and Letter of Agreement, along with a copy of the application for renewal to the national accrediting body at the same time as application is made to a national accrediting body.

b. HCBS staff shall furnish to the division copies of the letter notifying a provider of a forthcoming recertification for organizations deemed for supported community living under the HCBS mental retardation waiver.

c. Following the on-site review by a national accrediting body, the organization shall send the division a copy of the cover sheet and the national accrediting body report within 30 calendar days from the date that the organization receives the documents. If a corrective action plan is required, the organization shall send the division a copy of all correspondence and documentation related to the corrective action.

d. HCBS staff shall furnish the division with copies of HCBS certification reports and any corrective action required by HCBS within 30 calendar days after HCBS staff complete the report or the organization completes required corrective action.

441—24.7(225C) Complaint process. The division shall receive and record complaints by individuals using the services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules.

24.7(1) *Submittal of complaint.* The complaint may be delivered personally or by mail to the Division of Behavioral, Developmental, and Protective Services, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114, or by telephone (515)281-5874.

a. The division shall assist individuals in making a complaint as needed or requested.

b. The information received should specifically state the basis of the complaint. The division shall keep the name of the complainant confidential to the extent allowed by law.

24.7(2) *Review of complaint.* Upon receipt of a complaint, the division shall make a preliminary desk review of the complaint to determine an appropriate response. That response may include notifying the person who submitted the complaint that there is no basis for a review, referring the complaint to another investigative body, or making a determination to do a full investigation.

24.7(3) *Investigation of complaint.* If the division concludes that the complaint is reasonable, has merit, and is based on a violation of rules in this chapter, it may make an investigation of the organization. The division may investigate complaints by an office audit or by an on-site investigation. The division shall give priority for on-site investigations to instances when individuals using the service are in immediate jeopardy.

a. If a decision is made to conduct an on-site investigation, the on-site review does not require advance notice to the organization. The division shall notify the chief executive officer and board chairperson of the organization involved before or at the commencement of the on-site investigation that the division has received a complaint.

b. The division shall give the organization an opportunity to informally present a position regarding allegations in the complaint. The organization may submit the position in writing within five working days following the on-site visit or present it in a personal conference with division staff.

c. The division shall submit a written report by certified mail to the chief administrative officer of the organization and the chairperson of the board of directors within 20 working days after completion of the investigation.

d. The report shall indicate whether the complaint was or was not substantiated, the basis for the substantiation or nonsubstantiation, the specific rules violated, and a recommendation for corrective action with time lines specified in the report.

e. The date of delivery shown by the certified mail stub shall constitute the date of official notice.

24.7(4) *Review by commission.* When individuals receiving services are in immediate jeopardy, the commission may call an emergency meeting to make a decision on possible revocation or denial of accreditation.

a. To the extent allowed by Iowa Code section 21.5, the commission may review the complaint and investigation report in a closed meeting. The action taken by the commission shall be voted upon in the reconvened public meeting and entered into the official record of commission minutes.

b. If the complaint is substantiated, the commission make take actions deemed appropriate, which may include shortening the term of accreditation, requiring a corrective action plan, or suspending or revoking an organization's accreditation, depending on the severity of the substantiated complaint.

c. The division shall inform the complainant and the organization by certified mail of the findings and actions taken by the commission. The date of delivery shown by the certified mail stub shall constitute the date of official notice.

24.7(5) *Corrective action plan.* When the commission acts to suspend or revoke accreditation, there will be no corrective action plan. In other instances, if the complaint is substantiated, the organization shall submit a corrective action plan to the division within 20 calendar days after receiving

the commission's decision. This plan must respond to violations cited and commission requirements and include time lines, internal monitoring systems, and performance improvement planning.

Failure of the organization to respond within 20 calendar days with an acceptable corrective action plan that addresses the organization's plan of correction following a substantiated investigation or complaint may of itself constitute the basis for revocation or suspension of accreditation. The commission shall determine the appropriate action based on the information submitted. The division shall notify the organization of any action the commission takes.

441—24.8(225C) Appeal procedure. An appeal may be filed using the procedure identified in 441—Chapter 7. Notice of an appeal shall be sent to Appeals Section, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114, within 30 calendar days of the written decision from the commission.

441—24.9(225C) Exceptions to policy. Requests for exceptions to the policies in this chapter shall follow the policies and procedures in the department's general rule on exceptions to policy at 441—1.8(17A,217).

These rules are intended to implement Iowa Code chapter 225C.

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[1] Effective date of definitions of "Administrator," "Division" and "Persons with mental retardation" delayed 70 days by the Administrative Rules Review Committee at its meeting held April 10, 1995.

CHAPTER 25
DISABILITY SERVICES MANAGEMENT

PREAMBLE

This chapter provides for definitions of regional core services, access and practice standards, reporting of regional expenditures, development and submission of regional management plans, data collection, and applications for funding as they relate to regional service systems for individuals with mental illness, intellectual disabilities, developmental disabilities, or brain injury.

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DIVISION I
REGIONAL CORE SERVICES

441—25.1(331) Definitions.

"Assertive community treatment" means a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental disorders and individuals with complex symptomatology who require multiple mental health and supportive services to live in the community consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Assessment and evaluation" means the clinical review by a mental health professional of the current functioning of the individual using the service in regard to the individual's situation, needs, strengths, abilities, desires and goals to determine the appropriate level of care.

"Case management" means service provided by a case manager who assists individuals in gaining access to needed medical, social, educational, and other services through assessment, development of a care plan, referral, monitoring and follow-up using a strengths-based service approach that helps individuals achieve specific desired outcomes leading to a healthy self-reliance and interdependence with their community.

"Case manager" means a person who has completed specified and required training to provide case management through the medical assistance program or the Iowa Behavioral Health Care Plan.

"Community-based crisis intervention service" means a program designed to stabilize an acute crisis episode and to restore an individual and family to their pre-crisis level of functioning. Crisis services are available 24 hours a day, 365 days a year, including telephone and walk-in crisis service and crisis care coordination.

"Crisis care coordination" means a service provided during an acute crisis episode that facilitates working together to organize a plan and service transition programing, including working agreements with inpatient behavioral health units and other community programs. The service shall include referrals to mental health services and other supports necessary to maintain community-based living capacity, including case management as defined herein.

"Crisis evaluation" means the process used with an individual to collect information related to the individual's history and needs, strengths, and abilities in order to determine appropriate services or referral during an acute crisis episode.

"Day habilitation" means services that assist or support the individual in developing or maintaining life skills and community integration. Services shall enable or enhance the individual's functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

"Emergency care" means the same as defined in rule 441—88.21(249A).

"Evidence-based services" means using interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial and effective and have established standards for fidelity of the practice.

"Family psychoeducation" means services including the provision of emotional support, education, resources during periods of crisis, and problem-solving skills consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Family support" means services provided by a family support peer specialist that assist the family of an individual to live successfully in the family or community including, but not limited to, education and information, individual advocacy, family support groups, and crisis response.

"Family support peer specialist" means a parent, primary caregiver, foster parent or family member of an individual who has successfully completed standardized training to provide family support through the medical assistance program or the Iowa Behavioral Health Care Plan.

"Group supported employment" means the job and training activities in business and industry settings for groups of no more than eight workers with disabilities. Group settings include enclaves, mobile crews, and other business-based workgroups employing small groups of workers with disabilities in integrated, sustained, paid employment.

"Health homes" means a service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

"Home and vehicle modification" means a service that provides physical modifications to the home or vehicle that directly address the medical health or remedial needs of the individual that are necessary to provide for the health, welfare, and safety of the member and to increase or maintain independence.

"Home health aide services" means unskilled medical services which provide direct personal care. This service may include assistance with activities of daily living, such as helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician.

"Illness management and recovery" means a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals, reduce the individuals' susceptibility to the illness, and cope effectively with the individuals' symptoms consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Individual" means any person seeking or receiving services in a regional service system.

"Individual supported employment" means services including ongoing supports needed by an individual to acquire and maintain a job in the integrated workforce at or above the state's minimum wage. The outcome of this service is sustained paid employment that meets personal and career goals.

"Integrated treatment for co-occurring substance abuse and mental health disorders" means effective dual diagnosis programs that combine mental health and substance abuse interventions tailored for the complex needs of individuals with co-morbid disorders. Critical components of effective programs include a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interviews; provision of help to individuals in acquiring skills and supports to manage both illnesses and pursue functional goals with cultural sensitivity and competence consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Job development" means services that assist individuals in preparing for, securing and maintaining gainful, competitive employment. Employment shall be integrated into normalized work settings, shall provide pay of at least minimum wage, and shall be based on the individual's skills, preferences, abilities, and talents. Services assist individuals seeking employment to develop or re-establish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, and functional capacities to achieve positive employment outcomes.

"Medication management" means services provided directly to or on behalf of the individual by a licensed professional as authorized by Iowa law including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially

negative or unintended psychopharmacologic or medical interactions; reviewing laboratory reports; and activities pursuant to licensed prescriber orders.

"Medication prescribing" means services with the individual present provided by an appropriately licensed professional as authorized by Iowa law including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.

"Mental health outpatient therapy" means the same as defined in Iowa Code section 230A.106(2)*"a."*

"Mental health professional" means the same as defined in Iowa Code section 228.1(6).

"Peer support services" means a program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

"Peer support specialist" means an individual who has experienced a severe and persistent mental illness and who has successfully completed standardized training to provide peer support services through the medical assistance program or the Iowa Behavioral Health Care Plan.

"Permanent supportive housing" means voluntary, flexible supports to help individuals with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Tenants have access to an array of services that help them keep their housing, such as case management, assistance with daily activities, conflict resolution, and crisis response consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Personal emergency response system" means an electronic device connected to a 24-hour staffed system which allows the individual to access assistance in the event of an emergency.

"Prevocational services" means services that focus on developing generalized skills that prepare an individual for employment. Prevocational training topics include but are not limited to attendance, safety skills, following directions, and staying on task.

"Reasonably close proximity" means a distance of 100 miles or less or a driving distance of two hours or less from the county seat or county seats of the region.

"Respite services" means a temporary period of relief and support for individuals and their families provided in a variety of settings. The intent is to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a disability. Respite may be provided for a defined period of time; respite is either planned or provided in response to a crisis.

"Routine care" means the same as defined in rule 441—88.21(249A).

"Rural" means any area that is not defined as urban.

"Strengths-based case management" means a service that focuses on possibilities rather than problems and strives to identify and develop strengths to assist individuals reach their goals leading to a healthy self-reliance and interdependence with their community. Identifiable strengths and resources include family, cultural, spiritual, and other types of social and community-based assets and networks.

"Supported community living services" means services as defined in Iowa Code section 225C.21(1).

"Supported employment" means an approach to helping individuals participate as much as possible in competitive work in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Services are targeted for individuals with significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability including either individual or group supported employment, or both, consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

"Telephone crisis service" means a program that operates a crisis hotline either directly or through a contract. The service shall be available 24 hours a day and seven days a week including, but not limited to, relief of distress in pre-crisis and crisis situations, reduction of the risk of escalation, arrangements for emergency on-site responses when necessary, and referral of callers to appropriate services.

"Trauma-focused services" means services provided by caregivers and professionals that recognize when an individual who has been exposed to violence is in need of help to recover from adverse impacts; recognize and understand the impact that exposure to violence has on victims' physical, psychological, and psychosocial development and well-being; and respond by helping in ways that reflect awareness of adverse impacts and consistently support the individual's recovery.

"Trauma-informed care" means services that are based on an understanding of the vulnerabilities or triggers of those who have experienced violence, that recognize the role violence has played in the lives of those individuals, that are supportive of recovery, and that avoid retraumatization including trauma-focused services and trauma-specific treatment.

"Trauma-specific treatment" means services provided by a mental health professional using therapies that are free from the use of coercion, restraints, seclusion and isolation; and designed specifically to promote recovery from the adverse impacts of violence exposure on physical, psychological, psychosocial development, health and well-being.

"Urban" means a county that has a total population of 50,000 or more residents or includes a city with a population of 20,000 or more.

"Urgent nonemergency need" means the same as defined in rule 441—88.21(249A).

"Walk-in crisis service" means a program that provides unscheduled face-to-face support and intervention at an identified location or locations. The service may be provided directly by the program or through a contract with another mental health provider.

[**ARC 1096C**, IAB 10/16/13, effective 11/20/13]

441—25.2(331) Core service domains.

25.2(1) The region shall ensure that core service domains are available in regions as determined in Iowa Code section 331.397.

25.2(2) The region shall include and respect the recommendation of the individual and the individual's care team in the process of transition to new services.

25.2(3) The region shall ensure that the following services are available in the region:

a. Assessment and evaluation.
b. Case management.
c. Crisis evaluation.
d. Day habilitation.
e. Family support.
f. Health homes.
g. Home and vehicle modification.
h. Home health aide.
i. Job development.
j. Medication prescribing and management.
k. Mental health inpatient treatment.
l. Mental health outpatient treatment.
m. Peer support.
n. Personal emergency response system.
o. Prevocational services.
p. Respite.
q. Supported employment.
r. Supportive community living.
s. Twenty-four-hour access to crisis response.

Regions may fund or provide other services in addition to the required core services consistent with requirements set forth in subrules 25.2(4) and 25.2(5).

25.2(4) A regional service system shall consider the scope of services included in addition to the required core services. Each service included shall be described and projection of need and the funding necessary to meet the need shall be included.

25.2(5) A regional service system may provide funding for other appropriate services or other support. In considering whether to provide such funding, a region may consider the following criteria:

a. Applying a person-centered planning process to identify the need for the services or other support.

b. The efficacy of the services or other support is recognized as an evidence-based practice, is deemed to be an emerging and promising practice, or providing the services is part of a demonstration and will supply evidence as to the effectiveness of the services.

c. A determination that the services or other support provides an effective alternative to existing services that have been shown by the evidence base to be ineffective, to not yield the desired outcome, or to not support the principles outlined in *Olmstead v. L.C.,* 527 U.S. 581.

[**ARC 1096C**, IAB 10/16/13, effective 11/20/13]

441—25.3(331) Access standards. The region shall include:

25.3(1) A sufficient provider network which shall include:

a. A community mental health center or federally qualified health center that provides psychiatric and outpatient mental health services in the region.

b. A hospital with an inpatient psychiatric unit or state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant.

25.3(2) Crisis services shall be available 24 hours per day, seven days per week, 365 days per year for mental health and disability-related emergencies.

25.3(3) The region shall provide the following treatment services:

a. Outpatient.

(1) Emergency: During an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact.

(2) Urgent: Outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact.

(3) Routine: Outpatient services shall be provided to an individual within four weeks of request for appointment.

(4) Distance: Outpatient services shall be offered within 30 miles for an individual residing in an urban community and 45 miles for an individual residing in a rural community.

b. Inpatient.

(1) An individual in need of emergency inpatient services shall receive treatment within 24 hours.

(2) Inpatient services shall be available within reasonably close proximity to the region.

c. Assessment and evaluation. An individual who has received inpatient services shall be assessed and evaluated within four weeks.

25.3(4) A region shall provide the following basic crisis response:

a. Twenty-four-hour access to crisis response, 24 hours per day, seven days per week, 365 days per year.

b. Crisis evaluation within 24 hours.

25.3(5) Support for community living. The first appointment shall occur within four weeks of the individual's request of support for community living.

25.3(6) Support for employment. The initial referral shall take place within 60 days of the individual's request of support for employment.

25.3(7) Recovery services. An individual receiving recovery services shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

25.3(8) Service coordination:

a. An individual receiving service coordination shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

b. An individual shall receive service coordination within 10 days of the initial request for such service or being discharged from an inpatient facility.

25.3(9) The following limitations apply to home and vehicle modification for an individual receiving mental health and disability services:

a. A lifetime limit equal to that established for the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

b. A provider reimbursement payment will be no lower than that provided through the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

[**ARC 1096C**, IAB 10/16/13, effective 11/20/13]

441—25.4(331) Practices. A region shall ensure that access is available to providers of core services that demonstrate the following competencies:

25.4(1) Regions shall have service providers that are trained to provide effective services to individuals with two or more of the following co-occurring conditions:

a. Mental illness.

b. Intellectual disability.

c. Developmental disability.

d. Brain injury.

e. Substance use disorder.

Training for serving individuals with co-occurring conditions provided by the region shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the regional service system management plan.

25.4(2) Regions shall have service providers that are trained to provide effective trauma-informed care. Trauma-informed care training provided by the region shall be recognized by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the regional service system management plan.

25.4(3) Regions must have evidence-based practices that the region has independently verified as meeting established fidelity to evidence-based service models including, but not limited to, assertive community treatment or strengths-based case management; integrated treatment of co-occurring substance abuse and mental health disorders; supported employment; family psychoeducation; illness management and recovery; and permanent supportive housing.

[**ARC 1096C**, IAB 10/16/13, effective 11/20/13]

These rules are intended to implement Iowa Code chapter 331 and 2012 Iowa Acts, chapter 1120, section 15.

441—25.5 to **25.10** Reserved.

DIVISION II
REGIONAL SERVICE SYSTEM

PREAMBLE

These rules define the standards for a regional service system. The mental health and disability services provided by counties operating as a region shall be delivered in accordance with a regional service system management plan approved by the region's governing board and implemented by the regional administrator (Iowa Code section 331.393). Iowa counties are encouraged to enter into a regional system when the regional approach is likely to increase the availability of services to residents of the state who need the services. It is the intent of the Iowa general assembly that the adult residents of this state should have access to needed mental health and disability services regardless of the location of their residence.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.11(331) Definitions.

"Access point" means a provider, public or private institution, advocacy organization, legal representative, or educational institution with staff trained to complete applications and guide individuals with a disability to needed services.

"Applicant" means an individual who applies to receive services and supports from the service system.

"Assessment and evaluation" means the same as defined in rule 441—25.1(331).

"Assistive technology account" means funds in contracts, savings, trust or other financial accounts, financial instruments, or other arrangements with a definite cash value that are set aside and designated for the purchase, lease, or acquisition of assistive technology, assistive technology services, or assistive technology devices. Assistive technology accounts must be held separately from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology services or devices for a working individual with a disability. Any withdrawal from an assistive technology account other than for the designated purpose becomes a countable resource.

"Authorized representative" means a person designated by the individual or by Iowa law to act on the individual's behalf in specified affairs to the extent prescribed by law.

"Chief executive officer" means the person chosen and supervised by the governing board who serves as the single point of accountability for the mental health and disability services region and whose responsibilities include, but are not limited to, planning, budgeting, monitoring county and regional expenditures, and ensuring the delivery of quality services that achieve expected outcomes for the individuals served.

"Choice" means the individual or authorized representative chooses the services, supports, and goods needed to best meet the individual's goals and accepts the responsibility and consequences of those choices.

"Clear lines of accountability" means the structure of the governing board's organization makes it evident that the ultimate responsibility for the administration of the non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization's chief executive officer.

"Community" means an integrated setting of an individual's choice.

"Conflict-free case management" means there is no real or seeming incompatibility between the case manager's other interests and the case manager's duties to the individual served and includes case management separate from direct service provision; eligibility determination for services; establishment of funding levels for the individual's services; and requirements that prohibit the case manager from performing evaluations, assessments, and plans of care if the case manager is related by blood or marriage to the individual or any of the individual's paid caregivers or persons financially responsible for the individual or empowered to make financial or health-related decisions on behalf of the individual.

"Coordinator of disability services" means the same as defined in Iowa Code section 331.390(3)*"b."*

"Countable resource" means real or personal property that has a cash value that is available to the owner upon disposition and is capable of being liquidated.

"Countable value" means the equity value of a resource, which is the current fair market value minus any legal debt on the item.

"County of residence" means the same as defined in Iowa Code section 331.394.

"Department" means the department of human services.

"Director" means the director of human services.

"Disability services" means the same as defined in Iowa Code section 225C.2.

"Emergency service" means the same as defined in rule 441—88.21(249A).

"Empowerment" means that the service system ensures the rights, dignity, and ability of individuals and their families to exercise choices, take risks, provide input, and accept responsibility.

"Exempt resource" means a resource that is disregarded in the determination of eligibility for public funding assistance and in the calculation of client participation amounts.

"Homeless person" means the same as defined in Iowa Code section 48A.2.

"Household" means, for an individual who is 18 years of age or over, the individual, the individual's spouse or domestic partner, and any children, stepchildren, or wards under the age of 18 who reside with the individual. For an individual under the age of 18, "household" means the individual, the individual's parents (or parent and domestic partner), stepparents or guardians, and any children, stepchildren, or

wards under the age of 18 of the individual's parents (or parent and domestic partner), stepparents, or guardians who reside with the individual.

"Income" means all gross income received by the individual's household, including but not limited to wages, income from self-employment, retirement benefits, disability benefits, dividends, annuities, public assistance, unemployment compensation, alimony, child support, investment income, rental income, and income from trust funds.

"Individual" means any person seeking or receiving services in a regional service system.

"Individualized services" means services and supports that are tailored to meet the personalized needs of the individual.

"Liquid assets" means assets that can be converted to cash in 20 days. Liquid assets include but are not limited to cash on hand, checking accounts, savings accounts, stocks, bonds, cash value of life insurance, individual retirement accounts, certificates of deposit, and other investments.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors: achieving high-quality outcomes for participants, coordinating access, and containing costs.

"Managed system" means a system that integrates planning, administration, financing, and service delivery. The system consists of the financing or governing organization, the entity responsible for care management, and the network of service providers.

"Management organization" means an organization contracted to manage part or all of the service system for a region.

"Medical savings account" means an account that is exempt from federal income taxation pursuant to Section 220 of the U.S. Internal Revenue Code (26 U.S.C. §220) as supported by documentation provided by the bank or other financial institution. Any withdrawal from a medical savings account other than for the designated purpose becomes a countable resource.

"Mental health professional" means the same as defined in Iowa Code section 228.1(6).

"Non-liquid assets" means assets that cannot be converted to cash in 20 days. Non-liquid assets include, but are not limited to, real estate, motor vehicles, motor vessels, livestock, tools, machinery, and personal property.

"Population" means the same as defined in Iowa Code section 331.388.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance, is accredited under 441—Chapter 24, holds a professional license to provide the service, is accredited by a national insurance panel, or holds other national accreditation or certification.

"Regional administrator" or *"regional administrative entity"* means the administrative office or organization formed by agreement of the counties participating in a mental health and disability services region to function on behalf of those counties.

"Regional services fund" means the mental health and disability regional services fund created in Iowa Code section 225C.7A.

"Regional service system management plan" means the regional service system plan developed pursuant to Iowa Code section 331.393 for the funding and administration of non-Medicaid-funded mental health and disability services and includes an annual service and budget plan, a policies and procedures manual, and an annual report and how the region will coordinate with the department in the provision of mental health and disability services funded under the medical assistance program.

"Resources" means all liquid and non-liquid assets that are owned in part or in whole by the individual household, that could be converted to cash to use for support and maintenance, and that the individual household is not legally restricted from using for support and maintenance.

"Retirement account" means any retirement or pension fund or account listed in Iowa Code section 627.6(8)*"f."*

"Retirement account in the accumulation stage" means a retirement account into which a deposit was made in the previous tax year. Any withdrawal from a retirement account becomes a countable resource.

"Service system" refers to the mental health and disability services and supports administered by the regional administrative entity and paid from the regional services fund.

"State case status" means the standing of an individual who has no county of residence.

"State commission" means the same as defined in Iowa Code section 225C.5.

"System of care" means the coordination of a system of services and supports to individuals and their families that ensures they optimally live, work, and recreate in integrated communities of their choice.

"System principles" means practices that include individual choice, community and empowerment.
[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.12(331) Regional governance structure. The counties comprising a mental health and disability services region shall enter into an agreement to form a regional administrator under the control of a governing board to function on behalf of those counties as defined in Iowa Code chapter 28E and sections 331.388, 331.390 and 331.392 and 2013 Iowa Acts, House File 648, section 14.

25.12(1) *Governing board.* The governing board shall comply with the following requirements:

a. The governing board shall comply with the membership requirements as outlined in Iowa Code section 331.390 and follow the requirements in Iowa Code chapter 69 and other applicable laws relating to boards and commissions.

b. A regional advisory committee shall be created and shall designate members to the governing board as defined in Iowa Code section 331.390(2).

c. The governing board shall appoint and evaluate the performance of the chief executive officer of the regional administrative entity who will serve as the single point of accountability for the region.

25.12(2) *Regional administrator.* The formation of the regional administrator shall be as defined in Iowa Code sections 331.388 and 331.390.

a. The regional administrative entity is under the control of the governing board.

b. The regional administrative entity shall enter into and manage performance-based contracts in accordance with Iowa Code section 225C.4(1)*"u."*

c. The regional administrative entity structure shall have clear lines of accountability.

d. The regional administrative entity functions as a lead agency utilizing shared county or regional staff or other means of limiting administrative costs.

e. The regional administrative entity staff shall include one or more coordinators of disability services.

25.12(3) *Regional service system management.* The region may either directly implement a system of service management and contract with service providers, or contract with a private entity to manage the regional service system, provided all requirements of Iowa Code section 331.393 are met by the private entity.
[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.13(331) Regional finances.

25.13(1) *Funding.* Non-Medicaid mental health and disability services funding is under the control of the governing board and shall:

a. Be maintained to limit administrative burden and provide public transparency regarding financial processes.

b. Be maintained in one of three ways:

(1) In a combined account.

(2) In separate county accounts that are under the control of the governing board.

(3) In other arrangements authorized by law.

25.13(2) *Accounting system and financial reporting.* The accounting system and financial reporting to the department shall conform to Iowa Code section 331.391 and include all non-Medicaid mental health and disability expenditures. Information shall be separated and identified in a uniform chart of accounts, including but not limited to the following: expenses for administration; purchase of services; and enterprise costs for which the region is a service provider or is directly billing and collecting payments.
[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.14(331) Regional governance agreement. The expectations for regional governance agreements entered into by the counties comprising a mental health and disability services region are defined in Iowa Code sections 28E.1, 331.388, 331.390 and 331.392.

25.14(1) *Organizational provisions.* The organizational provisions of the regional governance agreement shall include the following:

a. A statement of purpose, goals, and objective of entering into the agreement.

b. Identification of the governing board membership and the terms, methods of appointment, and voting procedures, including whether or not voting will be weighted.

c. The identification of the process for selecting the executive staff, including but not limited to the chief executive officer of the regional administrative entity.

d. Identification of the counties participating in the agreement.

e. The time period of the agreement and terms for termination or renewal of the agreement.

f. Provisions for joining a region. Additional counties may join the region. The agreement shall not prohibit a county from being assigned by the department to a region according to Iowa Code section 331.389(4)*"c."*

g. Methods for dispute resolution and mediation.

h. Methods for termination of a county's participation in the region.

i. Provision for formation and assigned responsibilities for one or more advisory committees consisting of:

(1) Individuals who utilize services or the actively involved relatives of such individuals.

(2) Service providers.

(3) Governing board members.

(4) Other interests identified in the agreement.

25.14(2) *Administrative provisions.* The administrative provisions of the regional governance agreement shall include all of the following:

a. Identification of whether the region will either directly implement a system of service management or contract with a private entity to manage the regional service system as defined in Iowa Code section 331.393(7).

b. Responsibility of the governing board in appointing and evaluating the performance of the chief executive officer of the regional administrative entity.

c. A general list of the functions and responsibilities of the regional administrative entity's chief executive officer and other staff including but not limited to coordinators of disability services.

d. Specification of the functions to be carried out by each party to the agreement and by any subcontractor of a party to the agreement.

25.14(3) *Financial provisions.* The financial provisions of the regional governance agreement shall include all of the following:

a. Methods for pooling, managing and expending funds under control of the regional administrative entity. If the agreement does not provide for pooling of the participating county moneys in a single fund, the agreement shall specify how the participating county moneys will be subject to the control of the regional administrative entity.

b. Methods for allocating administrative funding and resources.

c. Methods for contributing initial funds to the region.

d. Methods for acquiring or disposing of real property.

e. The process for how to use savings achieved for reinvestment.

f. A process for performance of an annual independent audit of the regional administrator.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.15(331) Eligibility, diagnosis, and functional assessment criteria.

25.15(1) *Eligibility for mental health services.* An individual must comply with all of the following requirements to be eligible for mental health services under the regional service system:

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has had at any time during the preceding 12-month period a mental health, behavioral, or emotional disorder or, in the opinion of a mental health professional, may now have such a diagnosable disorder. The diagnosis shall be made in accordance with the criteria provided in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and shall not include the manual's "V" codes identifying conditions other than a disease or injury. The diagnosis shall also not include substance-related disorders, dementia, antisocial personality, or developmental disabilities, unless co-occurring with another diagnosable mental illness.

e. The results of a standardized functional assessment support the need for mental health services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for mental health services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(2) *Other conditions of eligibility for mental health services.*

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those mental health services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

25.15(3) *Eligibility for intellectual disability services.* An individual must comply with all of the following requirements to be eligible for intellectual disability services under the regional service system:

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has a diagnosis of intellectual disability as defined by Iowa Code section 4.1(9A).

e. The results of a standardized functional assessment support the need for intellectual disability services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for intellectual services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(4) *Other conditions of eligibility for intellectual disability services.*

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those intellectual disability services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

25.15(5) *Eligibility for brain injury services.* An individual must comply with all of the following requirements to be eligible for brain injury services under the regional service system, if such services were provided to the same class of individuals by a county in the region prior to regional formation and if funds are available to continue such services without limiting or reducing core services.

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has a diagnosis of brain injury as defined in Iowa Code section 83.81.

e. The results of a standardized functional assessment support the need for brain injury services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology used is the methodology approved for brain injury services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(6) *Other conditions of eligibility for brain injury services.* An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

25.15(7) *Eligibility for developmental disability services.*

a. Until funding is designated for other service populations, eligibility for the core service domains shall be as identified in Iowa Code section 331.397(1)*"b."*

b. If a county in a region was providing services to an eligibility class of individuals with a developmental disability other than intellectual disability prior to formation of the region, the class of individuals shall remain eligible for the services provided when the region is formed, providing that funds are available to continue such services without limiting or reducing core services. The individual must also meet the requirements in paragraphs 25.15(7)*"c," "d," "e"* and *"f."*

c. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

d. The individual is at least 18 years of age.

e. The individual is a resident of this state.

f. The individual has a diagnosis of a developmental disability other than an intellectual disability as defined in rule 441—24.1(225C).

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.16(331) Financial eligibility requirements. The regional service system management plan shall identify basic financial eligibility standards for disability services as defined in Iowa Code section 331.395.

25.16(1) *Income requirements.* Income requirements shall be as defined in Iowa Code section 331.395(1).

25.16(2) *Resource requirements.* An individual must have resources that are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

a. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

c. The following resources shall be exempt:

(1) The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than $1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

e. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

25.16(3) *Copayment standards.* A regional administrative entity must comply with copayment standards as defined in Iowa Code section 331.395.

a. Copayments are allowed for individuals with income above 150 percent of the federal poverty level.

b. Copayments in this rule are related to core services as defined in Iowa Code section 331.397.

25.16(4) *Copayment standards required by any federal, state, regional, or municipal program.* Any copayments or other client participation required by any federal, state, regional or municipal program in which the individual participates shall be required by the regional administrative entity. Such copayments include, but are not limited to:

a. Client participation for maintenance in a residential care facility through the state supplementary assistance program.

b. The financial liability for institutional services paid by counties as provided in Iowa Code section 230.15.

c. The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.8.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.17(331) Exempted counties. If a county has been exempted pursuant to Iowa Code section 331.389 from the requirement to enter into a regional service system, the county and the county's board of supervisors shall fulfill all the requirements of this chapter for a regional service system management plan.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.18(331) Annual service and budget plan. The annual service and budget plan shall describe the services to be provided and the cost of those services for the ensuing year.

25.18(1) The annual service and budget plan is due on April 1 prior to the July 1 implementation of the annual plan and shall be approved by the region's governing board prior to submittal to the department. The initial plan is due on April 1, 2014.

25.18(2) The annual service and budget plan shall include but not be limited to:

a. The locations of the local access points for services. This shall include the name of the access points including the physical locations and contact information.

b. Targeted case management. The targeted case management agencies for the region, including the physical location and contact information for those agencies, shall be included.

c. Crisis planning. The plan for ensuring effective crisis prevention, response and resolution, including contact information for the agencies responsible, shall be included.

d. Scope of services. A description of the scope of services to be provided, a projection of need for the service, and the funding necessary to meet the need shall be included.

(1) The scope shall include the regional core services as defined in rule 441—25.1(331).

(2) The scope shall also include services in addition to the required core services.

e. Budget and financing provisions for the next year. The provisions shall address how county, regional, state and other funding sources will be used to meet the service needs within the region.

f. Financial forecasting measures. The plan shall describe the financial forecasting measures used in the identification of service need and funding necessary for services.

g. The provider reimbursement provisions. The plan shall describe the types of reimbursement methods that will be used, including fee for service, compensating providers for a "system of care" approach, and use of nontraditional providers. A region also shall provide funding approaches that

identify and incorporate all services and sources of funding used by the individuals receiving services, including the medical assistance program.
[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.19(331) Annual service and budget plan approval. The annual service and budget plan shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the regional annual service and budget plan in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect until June 30, 2015, subject to amendment.

25.19(1) *Criteria for acceptance.* The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

25.19(2) *Notification.* Except as specified in subrule 25.19(3), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

a. The annual service and budget plan is approved as it was submitted, either with or without supplemental information already requested and received.

b. The annual service and budget plan will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

25.19(3) *Review of late submittals.* The director may review plans not submitted by April 1, 2014, after all plans submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.19(4) *Amendments.* An amendment to the annual service and budget plan shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the plan, the director must approve the amendment.

a. *Criteria for acceptance.* The director shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the annual service and budget plan and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. *Notification.* The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will include why the amendment is not approved.

25.19(5) *Reconsideration.* Regions dissatisfied with the director's decision on a plan or an amendment may file a letter with the director requesting reconsideration. The letter requesting reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.
[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.20(331) Annual report. The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. The annual report is due on December 1 following a completed fiscal year of implementing the annual service and budget plan. The initial report is due on December 1, 2015. The annual report shall include but not be limited to:

1. Services actually provided.
2. Actual numbers of individuals served.

3. Moneys expended.
4. Outcomes achieved.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.21(331) Policies and procedures manual for the regional service system. The policies and procedures manual shall describe the policies and process developed to direct the management and administration of the regional service system. The initial manual is due on April 1, 2014, and will remain in effect subject to amendment.

25.21(1) *Content.* The manual shall include but not be limited to:

a. Financing and delivery of services and supports. A description of the region's process used to develop and ensure the ongoing financial accountability and delivery of services outlined in the region's annual service and budget plan shall be included.

b. Enrollment. The application and enrollment process that is readily accessible to applicants and their families or authorized representatives shall be included. This procedure shall identify regional access points and where applicants can apply for services and how and when the applications will reach the regional administrative entity's designated staff for processing.

c. Eligibility. The process utilized to determine eligibility shall be included in the manual and shall include but not be limited to:

(1) The criteria used to authorize or deny funding for services and supports. This shall include guidelines for who is eligible to receive services and supports by eligibility group, and type of service or support.

(2) Financial eligibility and copayment criteria, which shall meet the requirements of rule 441—25.16(331).

(3) The time frames for conducting eligibility determination that provide for timely access to services, including necessary and immediate services not to exceed ten days.

(4) The process for development of a written notice of decision. The time frame for sending a written notice of decision to the individual and guardian (if applicable) and the service providers identified in the notice shall be included. The notice of decision shall:

1. Explain the action taken on the application and the reasons for that action.
2. State what services are approved and name the service providers.
3. Outline the applicant's right to appeal.
4. Describe the appeal process.

d. Utilization of and access to services. The process for managing utilization of and access to services and other assistance shall be included. The process shall describe how coordination between the services included in the annual service and budget plan and the disability services administered by the state and others will be managed.

e. Quality management and improvement process. The quality management and improvement process shall at a minimum meet the requirements of the department's outcome and performance measures process as outlined in Iowa Code sections 225C.4(1)*"j"* and 225C.6A.

f. Risk management and fiscal viability. If the region contracts with a private entity, the manual must include risk management provisions and fiscal viability of the annual services and budget plan.

g. Targeted case management.

(1) Designation of targeted case management providers. The process used to identify and designate targeted case management providers for the region shall be described. This process shall include the requirement for the implementation of evidence-based practice models of case management within the region. Requirements of this practice include:

1. Providing the individual receiving the case management with a choice of providers.
2. Allowing a service provider to be the case manager but prohibiting the provider from referring that individual only to services administered by the provider.
3. Provisions to ensure compliance with, but not exceed, federal requirements for conflict-free case management.

(2) Qualifications of targeted case managers. A region's manual shall require that any targeted case managers or other persons providing service coordination while working for the designated provider meet the qualifications of qualified case managers and supervisors as defined in rule 441—24.1(225C).

(3) Targeted case management and service coordination services. Targeted case management and service coordination services utilized in a regional service system shall include but are not limited to the following as defined in Iowa Code section 331.393(4)*"g"*:

1. Performance and outcome measures relating to the health, safety, work performance, and community residency of the individuals receiving the services.

2. Standards for delivery of the services, including but not limited to the social history, assessment, service planning, incident reporting, crisis planning, coordination, and monitoring for individuals receiving the services.

3. Methodologies for complying with the requirements of paragraph 25.21(1)*"g."* Methodologies may include the use of electronic record keeping and remote or Internet-based training.

h. System of care approach plan.

i. Decentralized service provision. Measures to provide services in a dispersed manner that meet the minimum access standards of core services and that utilize the strengths and assets of the service providers within and available to the region shall be included.

j. Provider network formation and management. The manual shall require that providers that are subject to license, accreditation or approval meet established standards. The manual shall detail the approval process, including criteria, developed to select providers that are not currently subject to license, accreditation or approval standards. The manual shall identify the process the regional administrative entity will use to contract with providers and manage the provider network to ensure it meets the needs of the individuals in the region. The provider network will include but is not limited to the following:

(1) A contract with a community mental health center that provides services in the individual's region or with a federally qualified health center that provides psychiatric and outpatient mental health services in the individual's region.

(2) Contracts with licensed and accredited providers to provide each service in the required core service domains.

(3) Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

(4) A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity.

k. Service provider payment provisions. A policy for payment of service providers which describes the method and process of paying for services and supports delivered to the region shall be included.

l. Grievance processes. The manual shall develop and implement processes for appealing the decisions of the regional administrative entity in the following circumstances:

(1) Nonexpedited appeal process. The appeal process shall be based on objective criteria, specify time frames, provide for notification in accessible formats of the decisions to all parties, and provide some assistance to individuals with disabilities using the process. Responsibility for the final step in the appeal process shall be a state administrative law judge in nonexpedited appeals.

(2) Expedited appeal process. This appeal process is to be used when the decision of the regional administrative entity concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to an individual's health or safety. This appeal process shall be performed by a mental health professional who is either the administrator of the division of mental health and disability services of the department of human services or the administrator's designee.

1. The appeal shall be filed within five days of receipt of the notice of decision by the regional administrative entity.

2. The expedited review by the division administrator or designee shall take place within two days of receipt of the request, unless more information is needed. There is an extension of two days from the time the new information is received.

3. The administrator shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual's health or safety, the order shall identify the type and amount of service which shall be provided for the individual. The administrator or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.

4. The decision of the administrator or designee shall be considered a final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

m. Implementation of interagency and multisystem collaboration and care coordination. The policies and procedures manual shall describe how the region will collaborate with other funders, other regional service systems, service providers, case management, individuals and their families or authorized representatives, and advocates to ensure that authorized services and supports are responsive to individuals' needs, consistent with system principles, and cost-efficient. The manual shall describe the process for collaboration with the court to ensure alternatives to commitment and to coordinate funding for services to individuals who are under court-ordered commitment services pursuant to Iowa Code chapter 229.

n. Addressing multioccurring needs. The policies and procedures manual shall include criteria and measures to be used to address the needs of individuals who have two or more co-occurring mental health, intellectual or other developmental disability, brain injury, or substance-related disorders. The manual shall also include criteria and measures to be used to address the needs of individuals with specialized needs.

o. Service management and functional assessment. The policies and procedures manual shall describe how functional assessments and service management will be incorporated in accordance with applicable requirements.

p. Service system management. The policies and procedures manual shall identify whether the region will be directly implementing a system of service management or will contract with a private entity to manage the regional service system. If the region contracts with a private entity, the region will ensure that all requirements of Iowa Code section 331.393 and these administrative rules are fulfilled.

q. Assistance to other than core service populations. The policies and procedures manual shall specify the services populations, other than core service populations, to whom the region will provide assistance if funding is available.

r. Waiting list criteria. The policies and procedures manual shall specify whether the region will use waiting lists. If the policy and procedures manual specifies the use of waiting lists for funding services and supports, it shall specify criteria for the use and review of each waiting list, including the criteria to be used to determine how and when an individual will be placed on a waiting list. The criteria will include how core services and additional core services will be impacted the least by budgetary limitations. The manual shall specify how waiting list data will be used in future planning.

25.21(2) *Approval.* The manual shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The manual shall be approved by the region's governing board and is subject to approval by the director of human services. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the manual in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect subject to amendment.

a. *Criteria for acceptance.* The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

b. *Notification.*

(1) Except as specified in subparagraph 25.21(2)*"b"*(2), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

1. The policies and procedures manual is approved as it was submitted, either with or without supplemental information already requested and received.

2. The policies and procedures manual will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

(2) Review of late submittals. The director may review manuals not submitted by April 1, 2014, after all manuals submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.21(3) *Amendments.* An amendment to the policy and procedures manual shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the manual, the director must approve the amendment.

a. Criteria for acceptance. The director, in consultation with the state commission, shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the policy and procedures manual and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. Notification. The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will explain why the amendment is not approved.

25.21(4) *Reconsideration.* Regions dissatisfied with the director's decision on a manual or an amendment may file a letter with the director requesting reconsideration. The letter of reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

These rules are intended to implement Iowa Code sections 331.388 to 331.398.

[**ARC 1173C**, IAB 11/13/13, effective 1/1/14]

441—25.22 to **25.40** Reserved.

DIVISION III
MINIMUM DATA SET

441—25.41(331) Minimum data set. Each county shall maintain data on all clients served through the MH/DD services fund.

25.41(1) *Submission of data.* Each county shall submit to DHS a copy of the data regarding each individual that the county serves through the central point of coordination process.

a. DHS state payment program, state supplementary assistance program, mental health institutes, state resource centers, Medicaid program, and Medicaid managed care contractors shall provide the equivalent data in a compatible format on the same schedule as the required submission from the counties.

b. DHS shall maintain the data in the data analysis unit for research and analysis purposes only. Only summary data shall be reported to policymakers or the public.

25.41(2) *Data required.* The data to be submitted are as follows:

a. Basic client information including a unique identifier, name, address, county of residence and county of legal settlement.

b. The state I.D. number for state payment cases.

c. Demographic information including date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, DSM IV diagnosis, ICD-9 diagnosis, disability group (i.e., mental retardation, developmental disability, chronic mental illness, mental illness), central point of coordination (county number preceded by A 1), and central point of coordination (CPC) name.

d. Service information including the decision on services, date of decision, date client terminated from CPC services and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

e. Counties shall not be penalized in any fashion for failing to collect data elements in situations of crisis or in outreach efforts to identify or engage people in needed mental health services. For the purposes of this rule:

(1) Situations of crisis include but are not limited to voluntary and involuntary hospitalizations, legal and transportation services associated with involuntary hospitalizations, emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.

(2) Outreach efforts to identify or engage people in needed mental health services include but are not limited to mental health advocate services; services for homeless persons, refugees, or other legal immigrants; services for state cases who do not have documentation with them and are unable to help the county locate appropriate records; consultation; education to raise public awareness; 12-step or other support groups for persons with dual disorders; and drop-in centers.

f. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 100 percent reporting of the data elements listed in this paragraph. Beginning with the data reported for state fiscal year 2008, less than 100 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph *"e"*:

(1) Client identifiers:

1. Lname3 (the first three letters of the client's last name).
2. Last4SSN (the last four digits of the client's social security number).
3. SEX (the client's sex).
4. BDATE (the client's birth date).

(2) CPC (central point of coordination).

(3) Payment information:

1. PYMTDATE (CoMIS payment date).
2. FUND CODE (CoMIS fund code).
3. DG (CoMIS diagnosis).
4. COACODE (CoMIS chart of accounts code).
5. BEGDATE (CoMIS service beginning date).
6. ENDDATE (CoMIS service ending date).
7. UNITS (CoMIS units of service).
8. COPD (CoMIS county paid).

(4) ValidSSN (valid social security number indicator).

(5) IsPerson (IsPerson indicator).

g. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 90 percent reporting of the data elements listed in this paragraph beginning with the data reported for fiscal year 2008. Less than 90 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph *"e"*:

(1) Application Date (application date).

(2) RESCO (residence county).

(3) LEGCO (legal county).

(4) Provider ID (vendor number).

h. The department shall analyze the data received on or before December 1 each year by December 15 or by the next business day if December 15 falls on a weekend or holiday.

(1) When a county's data submission does not meet the specifications in paragraph *"f"* or *"g,"* the department will notify the county by E-mail.

(2) The county shall have 30 days from the date of the E-mail notice to submit the missing data or to provide an explanation of why the data cannot be reported.

(3) If the county does not report the data or provide an adequate explanation within 30 days, the department shall find the county in noncompliance.

i. The department shall post the aggregate reports received by December 1 on the department's Web site within 90 days.

25.41(3) *Method of data collection.* A county may choose to collect this information using the county management information system (CoMIS) that was designed by the department or may collect the information through some other means. If a county chooses to use another system, the county must be capable of supplying the information in the same format as CoMIS.

a. Except as provided in subparagraph (3), each county shall submit the following files in Microsoft Excel format (version 97 to 2000) or comma-delimited text file (CSV) format using data from the associated CoMIS table or from the county's chosen management information system:

Files to submit	Associated CoMIS Table
WarehouseClient.xls or WarehouseClient.csv	Client Data
WarehouseIncome.xls or WarehouseIncome.csv	Income Review
WarehousePayment.xls or WarehousePayment.csv	Payment
WarehouseProvider.xls or WarehouseProvider.csv	Provider
WarehouseProviderServices.xls or WarehouseProviderServices.csv	tblProviderServices
WarehouseService.xls or WarehouseService.csv	Service Authorizations

(1) Paragraphs *"b"* through *"g"* list the data required in each file and specify the structure or description for each data item to be reported.

(2) The field names used in the report files must be exactly the same as indicated in the corresponding paragraph, including spaces, and must be entered in the first row for each sheet.

(3) The file labeled WarehouseService.xls or WarehouseService.csv or service authorization (described in paragraph *"g"* of this subrule) shall be removed from this requirement on June 30, 2011, if data from this file have not been used by that date.

b. File name: WarehouseClient.xls or WarehouseClient.csv.

Sheet name: Warehouse_Client_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute

Field Name	Data Type	Field Size	Format	Description
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
Last Update	Date	10	mm/dd/yyyy	Date of last update to client record
SID	Text	8	9999999a	State identification number of client, if applicable (format of a valid number is 7 digits plus 1 alphabetical character).
ADD1	Text	50		First address line
ADD2	Text	50		Second address line (if applicable)
CITY	Text	50		City address line
STATE	Text	2		State code
ZIP	Number	5	0 decimal places	5-digit ZIP code
ETHN	Number	1	0 decimal places	Ethnicity of client: 0 = Unknown 1 = White, not Hispanic 2 = African-American, not Hispanic 3 = American Indian or Alaskan native 4 = Asian or Pacific Islander 5 = Hispanic 6 = Other (biracial; Sudanese; etc.)
MARITAL	Number	1	0 decimal places	Marital status of client: 1 = Single, never married 2 = Married (includes common-law marriage) 3 = Divorced 4 = Separated 5 = Widowed
EDUC	Number	2	0 decimal places	Education level of the client
RARG	Number	2	0 decimal places	Residential arrangement of client: 1 = Private residence/household 2 = State MHI 3 = State resource center 4 = Community supervised living 5 = Foster care or family life home 6 = Residential care facility 7 = RCF/MR 8 = RCF/PMI 9 = Intermediate care facility 10 = ICF/MR 11 = ICF/PMI 12 = Correctional facility 13 = Homeless shelter or street 14 = Other
LARG	Number	1	0 decimal places	Living arrangement of client: 1 = Lives alone 2 = Lives with relatives 3 = Lives with persons unrelated to client
INS	Number	1	0 decimal places	Health insurance owned by client: 1 = Client pays 3 = Medicaid 4 = Medicare 5 = Private third party 6 = Not insured 7 = Medically Needy

Field Name	Data Type	Field Size	Format	Description
INSCAR	Text	50		First insurance company name, if applicable
INSCAR1	Text	50		Second insurance company name, if applicable
INSCAR2	Text	50		Third insurance company name, if applicable
VET	Text	1		Veteran status of client: Y = Yes N = No
CONSERVATOR	Number	1	0 decimal places	Conservator status of client: 1 = Self 2 = Other
GUARDIAN	Number	1	0 decimal places	Guardian status of client: 1 = Self 2 = Other
LEGSTAT	Number	1	0 decimal places	Legal status of client: 1 = Voluntary 2 = Involuntary, civil commitment 3 = Involuntary, criminal commitment
REFSO	Number	1	0 decimal places	Referral source of client: 1 = Self 2 = Family or friend 3 = Targeted case management 4 = Other case management 5 = Community corrections 6 = Social service agency other than case management 7 = Other
DSMIV	Text	50		DSM IV diagnosis code of client
ICD9	Text	50		ICD-9 diagnosis code (optional for county use; not tied to CoMIS entry)
DG	Number	2	0 decimal places	Disability group of client: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
Application Date	Date	10	mm/dd/yyyy	Date of client's initial application
Outcome decision	Number	1	0 decimal places	Decision on client's application: 1 = Application accepted 2 = Application denied 3 = Decision pending
Decision date	Date	10	mm/dd/yyyy	Date decision was made on client's application
Denial reason	Text	2		Denial reason code: 00 = Not applicable 01 = Over income guidelines 1A = Over resource guidelines 02 = Does not meet county plan criteria 2A = Legal settlement in another county 2B = State case 3A = Brain injury 3B = Alzheimer's 3C = Substance abuse 3D = Other 04 = Does not meet service plan criteria 05 = Client desires to discontinue process 5A = Client fails to return requested information

Field Name	Data Type	Field Size	Format	Description
Client exit date from CPC	Date	10	mm/dd/yyyy	Date client was terminated from CPC services
Exit reason	Number	1	0 decimal places	Reason client left the CPC system: 0 = Unknown 1 = Client voluntarily withdrew 2 = Client deceased 3 = Unable to locate consumer 4 = Ineligible due to reasons other than income 5 = Ineligible, over income guidelines 6 = Client moved out of state 7 = Client no longer needs service 8 = Client has legal settlement in another county
Review Date	Date	10	mm/dd/yyyy	Date of last application review
PhoneNumber	Text	50		Phone number of client
ValidSSN	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client has a valid social security number. If the client does not have a valid social security number, populate this field with NO.
IsPerson	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client is a person. If the client entry represents a nonperson such as administrative costs, populate this field with NO.

c. File name: WarehouseIncome.xls or WarehouseIncome.csv.
Sheet name: Warehouse_Income_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
EMPL	Number	2	0 decimal places	Employment situation of client: 1 = Unemployed, available for work 2 = Unemployed, unavailable for work 3 = Employed full-time 4 = Employed part-time 5 = Retired 6 = Student 7 = Work activity employment 8 = Sheltered work employment 9 = Supported employment 10 = Vocational rehabilitation 11 = Seasonally employed 12 = In the armed forces 13 = Homemaker 14 = Other or not applicable 15 = Volunteer
House Hold Size	Number	2	0 decimal places	Number of people in client's household
INCSOUR	Number	2	0 decimal places	Primary income source of client: 1 = Family and friends 2 = Private relief agency 3 = Social security disability benefits 4 = Supplemental Security Income 5 = Social security benefits 6 = Pension 7 = Food assistance 8 = Veterans benefits 9 = Workers compensation 10 = General assistance 11 = Family investment program (FIP) 12 = Wages
Public Assistance Payments	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security Disability	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
SSI	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
VA Benefits	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
R/R Pension	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Child Support	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Employment Wages	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Dividend Interest	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Other Income	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Description 1	Text	50		Description of "Other Income"
Cash on hand	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Checking	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Savings	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Stocks/Bonds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Time Certificates	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)

Field Name	Data Type	Field Size	Format	Description
Trust Funds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Other Resources	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 2	Text	50		Description of "Other Resources" (where applicable)
Other Resources 2	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 3	Text	50		Description of "Other Resources 2"
Date reviewed	Date	10	mm/dd/yyyy	Date income was last reviewed (where applicable)

d. File name: WarehousePayment.xls or WarehousePayment.csv. Sheet name: Warehouse_Payment_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
PYMTDATE	Date	10	mm/dd/yyyy	Date county approves or makes payment
VENNAME	Text	50		Vendor or provider paid
COCODE	Number	3	0 decimal places	County where service was provided
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for payment
BEGDATE	Date	10	mm/dd/yyyy	Beginning date of payment period
ENDDATE	Date	10	mm/dd/yyyy	Ending date of payment period
UNITS	Number	4	0 decimal places	Number of service units for payment
COPD	Currency	14	2 decimal places	Amount paid by the county
RECEIVED	Currency	14	2 decimal places	Amount received for reimbursement (if applicable)

e. File name: WarehouseProvider.xls or WarehouseProvider.csv. Sheet name: Warehouse_Provider_Transfer_Que. (If the provider has more than one office location, enter information for the headquarters office.)

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
Provider Address1	Text	50		Provider address line 1
Provider Address2	Text	50		Provider address line 2 (if applicable)
City	Text	50		Provider city
State	Text	2		Provider state code
Zip	Text	10		Provider ZIP code
COCODE	Number	3	0 decimal places	Provider county code
PhoneNumber	Text	50		Provider phone number
Date of Last Update	Date	10	mm/dd/yyyy	Provider last updated date

f. File name: WarehouseProviderServices.xls or WarehouseProviderServices.csv. Sheet name: Warehouse_Provider_Services_Tra.

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for service
RATE	Currency	14	2 decimal places	Payment rate

g. File name: WarehouseService.xls or WarehouseService.csv. Sheet name: Warehouse_Service_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 200 = Iowa nonresident 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
FUND CODE	Text	10		Fund code for service
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other category
COACODE	Number	5	0 decimal places	Chart of accounts code for service
Begin Date	Date	10	mm/dd/yyyy	Beginning date of service period
End Date	Date	10	mm/dd/yyyy	Ending date of service period
Ending Reason	Number	1	0 decimal places	Reason for terminating approval of service: 0 = NA 1 = Voluntary withdrawal 2 = Client no longer needs service 3 = Ineligible, over income guidelines 4 = Ineligible due to other than income 5 = Client moved out of state 6 = Client deceased 7 = Reauthorization
Units	Number	4	0 decimal places	Average number of service units approved monthly
Rate	Currency	14	2 decimal places	Dollar amount per service unit
Review Date	Date	10	mm/dd/yyyy	Date for next service review

This rule is intended to implement Iowa Code sections 331.438 and 331.439.

441—25.42 to **25.50** Reserved.

DIVISION IV
INCENTIVE AND EFFICIENCY POOL FUNDING

PREAMBLE

These rules establish requirements for counties to receive funding from the incentive and efficiency pool. To be eligible for these funds, a county must select five performance indicators, submit a proposal, collect data, report data, and show improvement over time on the selected performance indicators.

441—25.51(77GA,HF2545) Desired results areas. In order to receive funds from the incentive and efficiency pool established in 1998 Iowa Acts, House File 2545, section 8, subsection 2, each county shall collect and report performance measure data in the following areas:

25.51(1) *Equity of access.* Each county shall measure the extent to which services are available and used. Each county shall:

a. Report annually the total number of consumers served, as well as an unduplicated total of the number of consumers served by disability category.

b. Calculate and report annually the percentage of service provision by dividing the number of consumers served in a year by the county's population as defined in 1998 Iowa Acts, House File 2545, section 7.

c. Calculate and report annually the percentage of denial of access by dividing the number of new, completed applications denied by the total number of new applications for service that year. A new, completed application shall be defined as an initial application of a consumer or any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.

d. Report annually the county's eligibility guidelines, which may include, but are not limited to, the income level below which an individual or family must be in order to be eligible for county-funded services, the maximum amount of resources which an individual or family may have in order to be eligible for county-funded services, covered populations, and service access criteria.

25.51(2) *Community-based supports.* Each county shall measure the extent to which community-based supports are available and used. Each county shall calculate and report annually:

a. The service setting percentage by dividing the unduplicated number of persons served in each of the following service settings in a fiscal year by the total unduplicated number of consumers served, both in total and by population group: mental health institutes, state hospital schools, intermediate care facilities for the mentally retarded, other living arrangements over five beds as captured by the county chart of accounts, and employment settings which include sheltered workshops, enclaves and supported employment.

b. The home-based percentage by subtracting the number of consumers currently being served in residential placements from the total unduplicated number of consumers served, and dividing the difference by the total number of consumers served. The calculation shall be made both in total and by population group.

c. The inpatient spending percentage by dividing the amount the county spent for inpatient services by the amount the county spent for outpatient services. Each county shall also divide the unduplicated number of consumers who received inpatient services during the fiscal year by the total unduplicated number of consumers who received services during that same fiscal year. Inpatient services shall be defined as any acute care for which the county is wholly or partially financially responsible.

25.51(3) *Consumer participation.* Each county shall measure the extent to which consumers participate in all aspects of the service system.

a. Each county shall report annually on the number of opportunities during the year for consumers to participate in planning activities, which may include, but are not limited to, open forums, focus groups, consumer advisory committee meetings, and planning council meetings by calculating the total number of consumers participating in these activities and dividing by the unduplicated number of consumers served and also by the total population of the county. In addition, the county shall report duplicated and unduplicated total attendance at all of these meetings. These calculations shall be made for consumers and family members separately.

b. Each county which has a planning group shall calculate and report annually the planning group percentage by dividing the number of consumers who actively serve on the planning group by the total number of people on the planning group. This calculation shall be made for consumers and family members separately. For the purposes of this subrule, a planning group is any group of individuals designated by the board of supervisors, or if no designation has been made, any group acknowledged by the central point of coordination administrator as assisting in the development of the county management plan.

c. Each county shall conduct a consumer satisfaction survey following adoption of more detailed rules for the survey.

25.51(4) *Administration.* Each county shall measure the extent to which the county services system is administered efficiently and effectively. Each county shall:

a. Calculate and report annually the administrative cost percentage by dividing the amount spent administering the county services system by the total amount spent from the services fund for the fiscal year.

b. Calculate and report annually the service responsiveness average by measuring the number of days between the date a new, completed application was submitted and the date a notice of decision of eligibility was sent to the consumer, adding all of these numbers of days, and dividing by the total number of new, completed applications for the fiscal year. A new, completed application shall be defined as an initial application of a consumer or an application of any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.

c. Report annually the number of appeals filed as a percent of the unduplicated total number of consumers served per year.

441—25.52(77GA,HF2545) Methodology for applying for incentive funding. Beginning with the county management plan for the fiscal year which begins July 1, 1999, each county applying for funding under 1998 Iowa Acts, House File 2545, section 8, subsection 2, shall include with its county management plan a performance improvement proposal for improving the county's performance on at least five performance measures. Three of the measures must be selected from at least two of the desired results areas stated in rule 441—25.51(77GA,HF2545). For the remaining two measures, the county either may propose measures not identified in these rules or may use measures described in these rules. A performance improvement proposal is not a mandatory element of a county management plan.

25.52(1) *Performance improvement proposal.* Each county shall identify the performance measures which the county has targeted for improvement and shall propose a percentage change for each indicator. The proposal shall include the county's rationale for selecting the indicators and may include any supporting information the county deems necessary. The proposal shall describe the process the county will use to involve consumers in the evaluation.

25.52(2) *Committee responsibility.* The state county management committee shall review all county proposals, and may either accept the proposal, request modifications, or reject the proposal. In order to interpret and provide context for each county's performance improvement proposal, the state county management committee shall, by January 1, 1999, establish the background data to be collected and aggregated for all counties.

25.52(3) *County ineligibility.* A county which does not have an accepted proposal prior to July 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to July 1. The petition shall describe the circumstances which will cause the proposal to be delayed and identify the date by which the proposal will be submitted. In addition, the state county management committee may grant an extension for the purposes of negotiation.

441—25.53(77GA,HF2545) Methodology for awarding incentive funding. Each county shall report on all performance measures listed in this division, plus any additional performance measures the county has selected, by December 1 of each year.

25.53(1) *Reporting.* Each county shall report performance measure information on forms, or by electronic means, developed for the purpose by the department in consultation with the state county management committee.

25.53(2) *Scoring.* The department shall analyze each county's report to determine the extent to which the county achieved the levels contained in the proposal accepted by the state county management committee. Prior to distribution of incentive funding to counties, results of the analysis shall be shared with the state county management committee.

25.53(3) *County ineligibility.* A county which does not report performance measure data by December 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to December 1. The petition shall describe the circumstances which will cause the report to be delayed and identify the date by which the report will be submitted.

441—25.54(77GA,HF2545) Subsequent year performance factors. For any fiscal year which begins after July 1, 1999, the state county management committee shall not apply any additional performance measures until the county management information system (CoMIS) developed and maintained by the division of mental health and developmental disabilities has been modified, if necessary, to collect and calculate required data elements and performance measures and each county has been given the opportunity to establish baseline measures for those measures.

441—25.55(77GA,HF2545) Phase-in provisions.

25.55(1) *State fiscal year 1999.* For the fiscal year which begins July 1, 1998, each county shall collect data as required above in order to establish a baseline level on all performance measures. A county

which collects and reports all required data by December 1, 1999, shall be deemed to have received a 100 percent score on the county's performance indicators.

25.55(2) *State fiscal year 2000.* A county which submits a proposal with its management plan for the fiscal year which begins July 1, 1999, and reports the levels achieved on the selected performance measures by December 1, 2000, shall be deemed to have received a 100 percent score on the county's performance indicators, regardless of the actual levels achieved.

These rules are intended to implement 1998 Iowa Acts, House File 2545, section 8, subsection 2.

441—25.56 to **25.60** Reserved.

DIVISION V
RISK POOL FUNDING

PREAMBLE

These rules establish a risk pool board to administer the risk pool fund established by the legislature and set forth the requirements for counties for receiving and repaying funding from the fund.

441—25.61(426B) Definitions.

"Available pool" means those funds remaining in the risk pool less any actuarial and other direct administrative costs.

"Central point of coordination (CPC)" means the administrative entity designated by a county board of supervisors, or the boards of a consortium of counties, to act as the single entry point to the service system as required in Iowa Code section 331.440.

"Commission" means the mental health, mental retardation, developmental disabilities, and brain injury commission.

"Division" means the mental health and disability services division of the department of human services.

"Mandated services" means those services for which a county is required to pay. Mandated services include, but may not be limited to, the following:

1. The costs for commitments for persons with mental illness, chronic mental illness, mental retardation, or developmental disabilities.
2. Inpatient services at the state mental health institutes for persons with mental illness or chronic mental illness.
3. Inpatient services at the state resource centers for persons with mental retardation or developmental disabilities.
4. Medicaid-funded care in an intermediate care facility for persons with mental retardation.
5. Medicaid-funded partial hospitalization and day treatment services for persons with chronic mental illness.
6. Medicaid-funded case management services for persons with mental retardation or developmental disabilities and for anyone not covered under the Iowa Plan.
7. Services provided under the Medicaid home- and community-based services mental retardation waiver.
8. Services provided under the Medicaid home- and community-based services brain injury waiver for which the county is responsible according to rule 441—83.90(249A).
9. Medicaid habilitation services for persons with chronic mental illness.

"Services fund" means a county's mental health, mental retardation, and developmental disabilities services fund created in Iowa Code section 331.424A.

441—25.62(426B) Risk pool board. This ten-member board consists of two county supervisors, two county auditors, a member of the commission who is not a member of a county board of supervisors, a member of the county finance committee created in Iowa Code chapter 333A who is not an elected official, a representative of a provider of mental health or developmental disabilities services selected

from nominees submitted by the Iowa Association of Community Providers, and two central point of coordination administrators, all appointed by the governor, subject to confirmation by two-thirds of the members of the senate, and one member appointed by the director of the department of human services.

25.62(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson and vice-chairperson of the board.

b. Members appointed by the governor shall serve three-year terms.

25.62(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of the risk pool established by Iowa Code section 426B.5, subsection 2. In carrying out these duties, the board shall do all of the following:

a. Recommend to the commission for adoption rules governing the risk pool fund.

b. Determine application requirements to ensure prudent use of risk pool assistance.

c. Accept or reject applications for assistance in whole or in part.

d. Review the fiscal year-end financial records for all counties that are granted risk pool assistance and determine if repayment is required.

e. Approve actuarial and other direct administrative costs to be paid from the pool.

f. Compile a list of requests for risk pool assistance that are beyond the amount available in the risk pool fund for a fiscal year and the supporting information for those requests and submit the list and supporting information to the commission, the department of human services, and the general assembly.

g. Perform any other duties as mandated by law.

25.62(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, an action is carried by a majority of the qualified members of the board.

25.62(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division.

25.62(5) *Board meetings.*

a. The board shall meet in August of each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any county making application for risk pool funds must be represented at the board meeting for awarding funds when that request is considered.

(1) The division shall notify the county of the date, time and location of the meeting.

(2) Any other persons with questions about the date, time or location of the meeting may contact the Administrator, Division of Mental Health and Disability Services, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, telephone (515)281-7277.

c. The board shall comply with applicable provisions of Iowa's open meetings law, Iowa Code chapter 21.

25.62(6) *Records.* Any records maintained by the board or on behalf of the board shall be made available to the public for examination in compliance with Iowa's open records law, Iowa Code chapter 22. To the extent possible, before submitting applications, records and documents, applicants shall delete any confidential information. These records shall be maintained in the office of the division.

25.62(7) *Conflict of interest.* A board member cannot be a part of any presentation to the board of that board member's county's application for risk pool funds nor can the board member be a part of any action pertaining to that application.

25.62(8) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

25.62(9) *Report.* On or before March 1 and September 1 of each fiscal year, the department of human services shall provide the risk pool board with a report of the financial condition of each funding source administered by the board. The report shall include, but is not limited to, an itemization of the

funding source's balances, types and amount of revenues credited and payees and payment amounts for the expenditures made from the funding source during the reporting period.
[**ARC 7879B**, IAB 6/17/09, effective 6/1/09]

441—25.63(426B) Application process.

25.63(1) *Applicants.* A county may be eligible for risk pool assistance when the county demonstrates that it meets the conditions in this subrule.

a. *Basic eligibility.*

(1) The county complies with the requirements of Iowa Code section 331.439.

(2) The county levied the maximum amount allowed for the county's services fund under Iowa Code section 331.424A for the fiscal year of application.

(3) In the fiscal year that commenced two years before the fiscal year of distribution, the county's services fund ending balance under generally accepted accounting principles was equal to or less than 20 percent of the county's actual gross expenditures for that fiscal year.

b. *Circumstances indicating need for assistance.* Risk pool assistance is needed for one or more of the following purposes:

(1) To continue support for mandated services.

(2) To avoid the need for reduction or elimination of:

1. Critical services, creating risk to a consumer's health or safety;
2. Critical emergency or mobile crisis services, creating risk to the public's health or safety;
3. Services or other support provided to an entire disability category; or
4. Services or other support provided to maintain consumers in a community setting, creating risk of placement in a more restrictive, higher-cost setting.

25.63(2) *Application procedures.*

a. *Format for submission.* The county shall submit the application package electronically or send an original plus 15 copies to the division. Facsimiles are not acceptable.

b. *Deadline.* The division must receive the application no later than 4:30 p.m. on July 1 of each year; or, if July 1 is a holiday, Saturday or Sunday, the division must receive the application no later than 4:30 p.m. on the first working day thereafter.

c. *Signature.* The application shall be signed and dated by both the chairperson of the county board of supervisors and the central point of coordination administrator.

d. *Notice of receipt.* Staff of the division shall notify each county of receipt of the county's application.

e. *Content.* In addition to Form 470-3723, Risk Pool Application, the application package shall include the following forms for the fiscal year that commenced two years before the fiscal year of distribution:

(1) Form 634C, Service Area 4 Supporting Detail (pages 1 to 8).

(2) Form 638R, Statement of Revenues, Expenditures, and Changes in Fund Balance—Actual and Budget (pages 1 and 2).

(3) If the budget has been amended, Form 653A-R, Record of Hearing and Determination on the Amendment to County Budget (sheet 2), as last amended.

25.63(3) *Request for additional information.* Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county within four working days after July 1 to request the information needed to complete the application. If July 1 is a holiday, Saturday or Sunday, the division shall make this contact within five working days after July 1. The county shall submit the required information within five working days from the date of the division's request for the additional information.
[**ARC 7879B**, IAB 6/17/09, effective 6/1/09]

441—25.64(426B) Methodology for awarding risk pool funding. The risk pool board shall make an eligibility decision on each application within 45 days after receiving the application and shall make a funding decision no later than August 15.

25.64(1) *Notice of decision.* The risk pool board shall send a notice of decision of the board's action to the chairperson of the applying county's board of supervisors. Copies of the notice of decision shall be sent to the county auditor and the central point of coordination administrator.

25.64(2) *Distribution of funds.* The total amount of the risk pool shall be limited to the available pool for a fiscal year.

a. If the total dollar amount of the approved applications exceeds the available pool, the board shall prorate the amount paid for an approved application. The funds will be prorated to each county based upon the proportion of each approved county's request to the total amount of all approved requests.

b. The division shall authorize the issuance of warrants payable to the county treasurers for the amounts due. The warrants shall be issued on or before September 15.

[**ARC 7879B**, IAB 6/17/09, effective 6/1/09]

441—25.65(426B) Repayment provisions.

25.65(1) *Required repayment.* Counties shall be required to repay risk pool funds if the county's actual need for risk pool assistance was less than the amount of risk pool assistance granted to the county. The county shall refund the lesser of:

a. The amount of assistance awarded; or

b. An amount such that the fund balance after refund will not exceed 5 percent of the expenditures for the year as determined on a modified accrual basis.

25.65(2) *Year-end report.* Each county granted risk pool funds shall complete a year-end financial report as required by Iowa Code section 225C.6A(2)(c)(3). The division shall review the accrual information and notify the mental health risk pool board if any county that was granted assistance in the prior year received more than the county's actual need based on the submitted financial report.

25.65(3) *Notification to county.* The chairperson of the mental health risk pool board shall notify each county by January 1 of each fiscal year of the amount to be reimbursed. The county shall reimburse the risk pool within 30 days of receipt of notification by the chairperson of the mental health risk pool board. If a county fails to reimburse the mental health risk pool, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the central point of coordination administrator of the county.

[**ARC 7879B**, IAB 6/17/09, effective 6/1/09]

441—25.66(426B) Appeals. The risk pool board may accept or reject an application for assistance from the risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement Iowa Code section 426B.5, subsection 2.

441—25.67 to **25.70** Reserved.

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

PREAMBLE

These rules provide for use of an appropriation from the tobacco settlement fund to establish a risk pool fund which may be used by counties with limited county mental health, mental retardation and developmental disabilities services funds to pay for increased compensation of the service staff of eligible purchase of service (POS) providers and establish the requirements for counties for receiving and repaying the funding. Implementation of the rate increases contemplated by the tobacco settlement fund in a timely manner will require cooperation among all eligible counties and providers.

441—25.71(78GA,ch1221) Definitions.

"Adjusted actual cost" means a POS provider's cost as computed using the financial and statistical report for the provider's fiscal year which ended during the state fiscal year beginning July 1, 1998 (state fiscal year 1999), as adjusted by multiplying those actual costs by 103.4 percent or the percentage

adopted by the risk pool board in accordance with 2000 Iowa Acts, chapter 1221, section 3, subsection 3, paragraph *"c."*

"Department" means the Iowa department of human services.

"Division" means the mental health and developmental disabilities division of the department of human services.

"Financial and statistical report" means a report prepared by a provider and submitted to host counties that is prepared in accordance with department rules for cost determination set forth in 441—Chapter 150.

"Host county" means the county in which the primary offices of a POS provider are located. However, if a POS provider operates separate programs in more than one county, "host county" means each county in which a separate program is operated.

"Purchase of service provider" or *"POS provider"* means a provider of sheltered work, work activity, supported employment, job placement, enclave services, adult day care, transportation, supported community living services, or adult residential services paid by a county from the county's services fund created in Iowa Code section 331.424A under a state purchase of service or county contract.

"Risk pool board" means that board established by Iowa Code section 426B.5, subsection 3.

"Separate program" means a POS service operated in a county other than the county in which the provider's home office is located and for which the provider allocates costs separately from similar programs located in the county where the provider's home office is located.

"Services fund" means the fund defined in Iowa Code section 331.424A.

"Tobacco settlement fund loan" or *"TSF loan"* means the tobacco settlement fund risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

441—25.72(78GA,ch1221) Risk pool board. The risk pool board is organized and shall take action and keep minutes and records as set out in rule 441—25.62(426B).

A risk pool board member cannot be a part of any presentation to the board of that board member's county's application for tobacco settlement fund risk pool funds nor can the board member be a part of any action pertaining to that application. If a risk pool board member is employed by or is a board member of a POS provider whose increases in compensation caused the host county to apply to the fund, the board member cannot be a part of any presentation to the board nor can the board member be a part of any action pertaining to that application.

441—25.73(78GA,ch1221) Rate-setting process. For services provided on or after July 1, 2000, each county shall increase its reimbursement rates for each program to the lesser of the adjusted actual cost or 105 percent of the rate paid for services provided on June 30, 2000.

25.73(1) *Financial and statistical report.* Each provider of POS services shall submit a financial and statistical report to each host county for each program that the provider operates within that county. These reports shall include actual costs for each separate program for the provider's fiscal year that ended during state fiscal year 1999 and state fiscal year 2000. These reports shall be submitted to the central point of coordination (CPC) administrator of the host county or counties no later than August 15, 2000.

25.73(2) *Rate determination.* The CPC administrator in each host county shall receive and review provider financial and statistical reports for each separate program for which that county is the host county. If the host county determines that all or part of the provider's increase in costs is attributable to increases in service staff compensation and that the adjusted actual cost is more than the rate paid by the county on June 30, 2000, the CPC administrator shall notify the provider in writing of the new rate for each program no later than September 1, 2000.

If a rate paid for services provided on June 30, 2000, exceeds the adjusted actual cost, the county shall not be required to adjust the rate for services provided on or after July 1, 2000.

The provider shall, no later than September 11, 2000, send to the CPC administrator of any other counties with consumers in those programs a copy of the rate determination signed by the CPC administrator of the host county. A county may delay payment of the reimbursement rate established pursuant to this subrule until the risk pool board has completed action as to adopting or not adopting a different percentage for the definition of adjusted actual cost, provided however that any increased rates required by 2000 Iowa Acts, chapter 1221, section 3, subsection 2, paragraph *"c,"* shall be paid retroactively for all services provided on or after July 1, 2000.

25.73(3) *Exemptions.*

a. A POS provider that has negotiated a reimbursement rate increase with a host county as of July 1, 2000, has the option of exemption from the provisions of these rules. However, a county shall not be eligible to receive tobacco settlement funds for any rates established outside of the process established in these rules.

b. Nothing in these rules precludes a county from increasing reimbursement rates of POS providers by an amount that is greater than that specified in these rules. However, a county shall not be eligible for tobacco settlement funds for the amount of any rate increase in excess of the amount established pursuant to these rules.

441—25.74(78GA,ch1221) Application process.

25.74(1) *Who may apply.* If a county determines that payment of POS provider rates in accordance with these rules will cause the county to expend more funds in FY2001 than budgeted for POS services, the county may apply for assistance from the tobacco settlement fund. However, any fiscal year 2000 projected accrual basis fund balances in excess of 25 percent of fiscal year 2000 services fund gross expenditures will reduce the amount for which a county is eligible. In considering the cost of implementing these provisions, a county shall not include the cost of rate increases granted to any providers who fail to complete financial and statistical reports as provided in these rules.

25.74(2) *How to apply.* The county shall send the original and 15 copies of Form 470-3768, Tobacco Settlement Fund Risk Pool Application, to the division. The division must receive the application no later than 4:30 p.m. on September 25, 2000. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by the chairperson of the county board of supervisors, the county auditor, and the CPC administrator. Staff of the division shall notify each county of receipt of the county's application.

25.74(3) *Request for additional information.* Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county by October 5, 2000, and request the information needed to complete the application. The county shall submit the required information by October 16, 2000.

441—25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding.

25.75(1) *Review of applications.* The risk pool board shall review all of the applications from counties for assistance from the tobacco settlement fund. If the total amount requested from the tobacco settlement fund does not exceed $2 million, eligible counties shall be awarded funding pursuant to this division. The risk pool board shall determine for each county whether any or all of the assistance granted to that county is a TSF loan.

25.75(2) *Notice of decision.* The risk pool board shall notify the chair of the applying county's board of supervisors of the board's action no later than November 3, 2000. Copies shall be sent to the county auditor and the CPC administrator.

25.75(3) *Distribution of funds.* The total amount of the risk pool shall be limited to $2 million. If the total dollar amount of the eligible applications exceeds the available pool, the risk pool board shall revise the percentage adjustment to actual cost to arrive at adjusted actual cost as defined in this division and prorate funding to the eligible counties. If it becomes necessary to revise the percentage adjustment used to determine adjusted actual cost, the risk pool board shall determine if applicant counties remain eligible under this program.

25.75(4) *Notification of adjustment.* If the risk pool board rolls back the percentage adjustment used to determine adjusted actual cost, the risk pool board shall notify the chair of the board of supervisors of all counties, and copies shall be sent to the county auditor and the CPC administrator of each county. Each host county shall recalculate the reimbursement rate under this division using the revised adjusted actual cost percentage and notify each provider in writing of the revised rate within 30 days of receiving notice of the percentage adjustment. The provider shall, within 30 days of receipt of notice, send to the CPC administrator of any other counties with consumers in those programs a copy of the revised rate determination signed by the CPC administrator of the host county.

441—25.76(78GA,ch1221) Repayment provisions.

25.76(1) *Required repayment.* Counties shall be required to repay TSF loans by January 1, 2002. Repayments shall be credited to the tobacco settlement fund.

25.76(2) *Notification to county.* In the notice of decision provided pursuant to these rules, the chairperson of the risk pool board shall notify each county of the portion, if any, of the assistance that is considered a TSF loan. If a county fails to reimburse the tobacco settlement fund by January 1, 2002, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the CPC administrator of the county.

441—25.77(78GA,ch1221) Appeals. The risk pool board may accept or reject an application for assistance from the tobacco settlement fund risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement 2000 Iowa Acts, chapter 1221, section 3, as amended by chapter 1232, section 4.

441—25.78 to **25.80** Reserved.

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

PREAMBLE

This division establishes a process for the mental health and developmental disabilities commission to grant a waiver to any county not affiliated with a community mental health center.

441—25.81(225C) Waiver request. Counties that have not established or that are not affiliated with a community mental health center under Iowa Code chapter 230A are required to expend a portion of the money received from the MI/MR/DD/BI community services fund to contract with a community mental health center for services. When a county determines that a contractual arrangement is undesirable or unworkable, it may request a waiver from this requirement for a fiscal year. The waiver request and justification may be submitted to the mental health and developmental disabilities commission with the application for MI/MR/DD/BI community services funds on Form 470-0887, Waiver Request, or it may be submitted separately. The commission may grant a waiver if the request successfully demonstrates that all of the following conditions are met:

25.81(1) *Accreditation of provider.* The provider or network of providers that the county has contracted with to deliver the identified mental health services is accredited as another mental health provider pursuant to 441—Chapter 24.

25.81(2) *Contracted services.* The county has contracted to provide services that are equal to or greater than the smallest set of services provided by an accredited community mental health center in the department's service area for that county.

25.81(3) *Eligible populations.* The county contract includes the following eligible populations:

a. Children.

b. Adults.

c. Elderly.

d. Chronically mentally ill.

e. Mentally ill.

This rule is intended to implement Iowa Code section 225C.7.

441—25.82 to **25.90** Reserved

DIVISION VIII
CRITERIA FOR EXEMPTING COUNTIES FROM JOINING INTO REGIONS TO ADMINISTER
MENTAL HEALTH AND DISABILITY SERVICES

441—25.91(331) Exemption from joining into mental health and disability services region.

25.91(1) *Definitions.*

"Applicant" means a single county or two counties that submit an application for an exemption from the requirement to join a region of three or more contiguous counties.

"Clear lines of accountability" means the governing board's organizational structure makes it evident that the ultimate responsibility for the administration of non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization's chief executive officer.

"Coordinator of disability services" means a person who meets the qualifications of a coordinator of disability services as defined in Iowa Code section 331.390(3)*"b"* and is responsible for ensuring that individuals receive effective service coordination consistent with the county's or counties' management plan.

"Core services" means core services mandated to be provided by the regional service system as defined in Iowa Code section 331.397.

"Department" means the Iowa department of human services.

"Director" means the director of the department.

"Evidence-based practice" means interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial, and effective.

"Penetration rate," for the purposes of this rule, means the per capita number of adults in the adult population of a county who are receiving mental health and disability services.

"Reasonably close proximity" means a distance of 100 miles or less or a driving distance of two hours or less from the county seat or county seats of the applicant.

"Trauma-informed care" means services that are based on an understanding of the vulnerabilities or triggers of individuals who have experienced trauma, recognize the role trauma has played in the lives of those individuals, are supportive of trauma recovery, and avoid retraumatization.

25.91(2) *Application for exemption from the requirement to form a region of three or more contiguous counties.* The following requirements apply to an application for exemption from the requirement to form a region of three or more contiguous counties:

a. The applicant shall submit a written statement that the applicant intends to apply for an exemption from the requirement to form a region of three or more contiguous counties. The statement must be signed by the chairperson of the county board of supervisors of the applicant's county. The signed written statement of intent must be received by the department on or before May 1, 2013, at 4:30 p.m.

b. The applicant shall submit a written application on forms specified by the department with required supporting documentation. The department shall only accept applications that are complete, signed by the applicant's chairperson of the county board of supervisors, dated, and received by the department on or before June 30, 2013, at 4:30 p.m.

c. The director of the department shall issue a decision on the application within 45 days of receiving the application. The director shall deny an application if the application does not meet the criteria described in Iowa Code or rule.

25.91(3) *Applicant criteria.* The application shall include written documentation and evidence that the applicant has:

a. The capacity to provide required core services and perform required functions described in Iowa Code section 331.397.

b. A contract with a community mental health center or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent from the community mental health center or federally qualified health center to enter into such a contract.

c. A contract with a hospital with an inpatient psychiatric unit or a state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant or written intent from the state mental health institute or inpatient psychiatric unit to enter into such a contract.

d. An administrative structure with clear lines of accountability. A description of the applicant's administrative functions shall be included with the application.

e. Taken steps to determine and demonstrate that forming a region of three or more contiguous counties is not workable.

25.91(4) *Core services and required functions standards.* The department shall review the application to determine if the applicant has provided written documentation and evidence for the availability of:

a. A 24-hour, 7-day-a-week, 365-days-per-year telephone response system for mental health and disability-related emergencies in the applicant's county or counties.

b. Service providers in the applicant's county or counties that demonstrate the capability of providing evidence-based practices that the applicant has independently verified meet established fidelity to evidence-based service models including, but not limited to:

(1) Assertive community treatment or strengths-based case management.

(2) Integrated treatment of co-occurring substance abuse and mental health disorders.

(3) Supported employment.

(4) Family psychoeducation.

(5) Illness management and recovery.

(6) Permanent supportive housing.

c. Service providers in the applicant's county or counties that are trained to provide effective services to persons with two or more of the following co-occurring conditions: mental illness, intellectual disability, developmental disability, brain injury, or substance use disorder. Training for serving persons with co-occurring conditions shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the application.

d. Service providers in the applicant's county or counties that are trained to provide effective trauma-informed care. Trauma-informed care training shall be training identified by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the application.

25.91(5) *Service capacity.* The department shall review the material provided in the application and by the applicant and other counties in their required county reports to determine if the applicant demonstrates that it has:

a. Sufficient financial resources to fund required core services.

b. A penetration rate that is at least equal to or exceeds the statewide per capita average for individuals with a mental illness or individuals with an intellectual disability.

c. A per capita use of inpatient psychiatric hospital services that is less than or equal to the statewide per capita average.

d. A per capita use of intermediate care facilities for individuals with intellectual disabilities that is less than or equal to the statewide per capita average.

e. A per capita use of outpatient mental health services that is greater than or equal to the statewide per capita average.

f. A per capita use of supported community living services that is greater than or equal to the statewide per capita average.

g. An average cost of service per individual served that is equal to or less than the statewide average.

h. Administrative costs, as a percentage of non-Medicaid service expenditures, that are less than or equal to the statewide average.

25.91(6) *Provider network sufficiency.* The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. A contract with a community mental health center that provides services in the applicant's county or counties or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent by a community mental health center or federally qualified health center to enter into such a contract.

b. Contracts with licensed and accredited providers to provide each service in the required core service domains or written intent by providers to enter into such contracts.

c. Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

d. A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity or written intent by an inpatient psychiatric hospital unit or state mental health institute to enter into such a contract.

25.91(7) to **25.91(9)** Reserved.

25.91(10) *Staffing.* The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. Clear lines of accountability.

b. The inclusion of one or more coordinators of disability services on the county administrator staff.

25.91(11) Reserved.

25.91(12) *Determination that formation of a region is unworkable.* The department shall review the application to determine if the applicant has provided documentation and convincing evidence that the applicant has evaluated the feasibility of forming into a region of three or more contiguous counties and that forming into such a region is unworkable.

25.91(13) *Compliance with requirements of a mental health and disability services region.* The applicant shall continuously fulfill all of the requirements of a region under Iowa Code chapters 331 and 225C for a regional service system, regional service system management plan, regional governing board, and regional administrator and any other requirements applicable to a region of counties providing local mental health and disability services. If the applicant does not fulfill these requirements, the department may address the deficiencies in the following order:

a. Require compliance with a corrective action plan that may include, but is not limited to, participation in technical assistance provided or arranged by the department, revision of the regional management plan, or other corrective actions required by the department.

b. Reduce the amount of the annual state funding provided through the mental health and disabilities regional services fund for the regional service system, not to exceed 15 percent of the amount of the annual state funding.

c. Withdraw approval for the county exemption.

This rule is intended to implement Iowa Code section 331.389.

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◊ Two or more ARCs

CHAPTER 26
COUNTY MAINTENANCE OF EFFORT CALCULATIONS AND REPORTING
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 27
Reserved

CHAPTER 28
POLICIES FOR MENTAL HEALTH INSTITUTES AND RESOURCE CENTERS

[Prior to 7/1/83, Social Services [770] Ch 28]
[Prior to 2/11/87, Human Services [498]]

441—28.1(218) Definitions. The definitions in this rule apply to 441—Chapters 28, 29, and 30.

"Admission" means the acceptance of an individual for receipt of services at a state mental health institute or resource center on either a voluntary or involuntary basis.

"Adult" means an individual who is 18 years of age or older.

"Board of supervisors" means the elected governing body of a county as defined in Iowa Code section 331.101.

"Catchment area" means the group of counties, designated by the division administrator, that each mental health institute or state resource center is assigned to serve.

"Central point of coordination process" means the process defined in Iowa Code section 331.440(1)*"a."*

"County of residence" means the same as defined in Iowa Code section 331.394.

"Division administrator" means the administrator of the division of mental health and disability services.

"Facility" means a mental health institute or state resource center referenced in Iowa Code section 218.1.

"Family contact," for an adult individual, means:

1. The family member the individual has designated in writing to receive information concerning the individual's services; or
2. A person, often referred to as a substitute decision maker, who has been legally authorized to make care decisions for the individual if the individual loses decision-making capacity.

"Grievance" means a written or oral complaint by or on behalf of an individual involving:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Guardian" means the person other than a parent of a minor who has been appointed by the court to have custody of the person of the individual as provided under Iowa Code section 232.2(21) or 633.3(20).

"Individual" means any person seeking or receiving services from a state mental health institute or a state resource center.

"Informed consent" means an agreement by an individual or by the individual's parent, guardian, or legal representative to participate in an activity based upon an understanding of all of the following:

1. A full explanation of the procedures to be followed, including an identification of those that are experimental.
2. A description of the attendant discomforts and risks.
3. A description of the benefits to be expected.
4. A disclosure of appropriate alternative procedures that would be advantageous for the individual.
5. Assurance that consent is given freely and voluntarily without fear of retribution or withdrawal of services.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Minor" means an individual under the age of 18.

"Non-Medicaid payment-eligible" means that an individual is not eligible for Medicaid funding for the services provided by a mental health institute or state resource center.

"Official designated agent" means a person or agency designated, by a record vote of the county board of supervisors, to act on behalf of the county board of supervisors.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Regional administrator" means the same as defined in Iowa Code section 331.388.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"State case" means the determination made under Iowa Code section 331.394 that an individual does not have a county of residence in an Iowa county and places funding responsibility with the state.

"Superintendent" means the superintendent of any of the four mental health institutes and the two state resource centers.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.2(218,222) Selection of facility.

28.2(1) Application for voluntary admission to a state mental health institute or resource center shall be made to the facility in the catchment area, as defined in rule 441—29.1(218) or 441—30.1(218,222), within which the individual for whom admission is sought has a county of residence.

28.2(2) Court commitment of an individual shall be made:

a. To the facility in the catchment area, as defined in rule 441—29.1(218) or 441—30.1(218,222), within which the individual who is being committed has a county of residence; or

b. As designated by the division administrator.

28.2(3) The division administrator shall consider granting exceptions to the established catchment areas when requested by the individual seeking a voluntary admission or by the committing court. The division administrator's decision shall be made within 48 hours of receipt of the request. The decision shall be based on:

a. The clinical needs of the individual;

b. The availability of appropriate program services;

c. Available bed space within the program at the requested facility; and

d. The consent of the superintendents of both facilities involved.

This rule is intended to implement Iowa Code sections 218.19, 218.20, and 222.6.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.3(222,230) Evidence of legal settlement. Rescinded **ARC 1145C**, IAB 10/30/13, effective 1/1/14.

441—28.4(225C,229) Grievances. Any individual who believes the individual's rights have been violated by a mental health institute or resource center or who has any complaint concerning the individual's treatment at a mental health institute or resource center may file a grievance. A grievance shall be filed using Form 470-4498, Individual Grievance. The individual's parent, family, guardian, or legal representative may file a grievance on behalf of the individual.

This rule is intended to implement Iowa Code sections 225C.27and 229.23.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—28.5(217,218) Photographing and recording of individuals and use of cameras.

28.5(1) Use of still or video cameras or voice recorders by anyone other than an authorized employee, individual, parent, guardian, or legal representative to photograph or record an individual shall be allowed only with the prior authorization of the superintendent or the superintendent's designee. Permission to photograph and record shall be granted for one specific use, and the authorization shall not extend to any other use.

28.5(2) Photographs, videos, and recordings of an adult individual shall be taken for publication only with a signed informed consent from the individual or the individual's guardian or legal representative.

28.5(3) Photographs, videos, and recordings of a minor individual shall be taken for publication only with a signed informed consent from the parent, guardian, or legal representative.

28.5(4) Every effort shall be made to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

28.5(5) Photographs, videos, and recordings of individuals are not to be altered to prevent identification in any manner that would tend to perpetuate the stigma attached to the public image of individuals with mental illness or an intellectual disability.

This rule is intended to implement Iowa Code sections 217.30 and 218.4.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.6(217,218) Interviews and statements.

28.6(1) Releases to the news media shall be the responsibility of the superintendent. Authority for dissemination and release of information may be designated to other employees at the discretion of the superintendent.

28.6(2) Interviews of individuals by the news media or other outside persons or groups shall be permitted only with the consent of the individual or the individual's parent, guardian, or legal representative.

a. When a request without known prior consent is received, the superintendent or designee shall not acknowledge the presence or nonpresence of an individual at the facility.

b. If the individual is in the facility, the superintendent or designee shall make the individual or the individual's parent, guardian, or legal representative aware of the request. Notice to the individual or the individual's parent, guardian, or legal representative shall be documented in the individual's record. The individual or the individual's parent, guardian, or legal representative shall be free to decide whether an interview is granted.

This rule is intended to implement Iowa Code sections 217.30 and 218.4.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.7(218) Use of grounds, facilities, or equipment.

28.7(1) The superintendent or designee may grant permission for temporary use of assembly halls, auditoriums, meeting rooms, or facility grounds to an organization or group of citizens when the space or grounds are available and are not needed for regular scheduled departmental services.

28.7(2) Members of outside organizations permitted to use a facility's space or grounds shall observe the same rules as visitors to the facility.

[**ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.8(218) Tours of facility. Groups or persons shall be permitted to tour the facility only with approval of the superintendent or designee.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.9(218) Donations. Donations of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the superintendent or designee. The superintendent or designee shall evaluate the donation in terms of the nature of the contribution to the facility's program. The superintendent or designee shall be responsible for accepting the donation and reporting the gift to the division administrator. All monetary gifts shall be acknowledged in writing to the donor.

This rule is intended to implement Iowa Code chapter 218.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.10(218) Residents' rights for the mentally retarded. Rescinded IAB 9/9/09, effective 11/1/09.

441—28.11(218) Catchment areas. Rescinded IAB 9/9/09, effective 11/1/09.

441—28.12(217) Release of confidential information. Information defined by statute as confidential concerning individuals who currently receive or formerly received services from the mental health institutes or resource centers shall not be released to a person, agency or organization that is not authorized by law to have access to the information unless the individual, parent, guardian, or

legal representative authorizes the release. Authorization shall be given by using Form 470-3951, Authorization to Obtain or Release Health Care Information.

This rule is intended to implement Iowa Code section 217.30.

[**ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—28.13(218) Applying county institutional credit balances.

28.13(1) *Definition of credit balance.* A county institutional credit balance occurs when a county has paid a debt from a state institution or an institutional program and it is later determined that all or part of the debt was not the county's responsibility. Only when an institutional debit balance has been paid by a county and all or part of the paid debit has been determined not to be the responsibility of the county can the resulting county credit be used to reduce existing or future institutional debit balances.

28.13(2) *Order of application.* County institutional credits shall be applied in the following order until all credits are exhausted or refunded:

a. A credit shall first be applied to the patient's or resident's account at the same institution that generated the credit.

b. If any credit remains after application to the patient's or resident's account, the remaining credit shall be applied to any outstanding charges at the same institution that generated the credit.

c. Any remaining credit, after application to the patient's or resident's account and to the same institution that generated the credit, shall be applied to an outstanding balance at another state institution.

(1) If a credit generated by an institution or institutional program under net budgeting is to be applied to an institution or institutional program not under net budgeting, then a transfer of funds shall be made from the applicable institutional fund or institutional program under net budgeting to the state general fund.

(2) If a credit generated by an institution that is not under net budgeting is to be applied to an institution or institutional program under net budgeting, the county may seek a refund by filing a claim to the state appeal board pursuant to 543—Chapter 3, or the county may allow the credit to remain outstanding until the county has an additional debt at a state institution or institutional program that is not under net budgeting.

(3) If a credit generated by an institution or institutional program under net budgeting is to be applied to another institution or institutional program under net budgeting, then the transfer of funds between the applicable net budgeting funds or programs shall be made through an accounting journal entry.

d. If any credit remains after applying credits as stated in paragraphs *"a"* to *"c,"* the county with the remaining credit may seek a refund by filing a claim to the state appeal board pursuant to 543—Chapter 3, or the county may allow the credit to remain outstanding until such time as the county has an additional state institution or an institutional program debt.

This rule is intended to implement Iowa Code section 218.78.

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CHAPTER 29
MENTAL HEALTH INSTITUTES

PREAMBLE

This chapter sets policies for the state mental health institutes listed in Iowa Code section 218.1. These rules apply in addition to the general rules in 441—Chapter 28.

441—29.1(218) Catchment areas. The catchment areas for the four mental health institutes shall be as follows.

29.1(1) *Cherokee.* Audubon, Boone, Buena Vista, Calhoun, Carroll, Cerro Gordo, Cherokee, Clay, Crawford, Dallas, Dickinson, Emmet, Franklin, Greene, Guthrie, Hamilton, Hancock, Hardin, Harrison, Humboldt, Ida, Kossuth, Lyon, Marshall, Monona, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Polk, Pottawattamie, Sac, Shelby, Sioux, Story, Webster, Winnebago, Woodbury, Worth, and Wright Counties form the catchment area for the Cherokee mental health institute.

29.1(2) *Clarinda.* Adair, Adams, Cass, Clarke, Decatur, Fremont, Madison, Mills, Montgomery, Page, Ringgold, Taylor, Union, Warren, and Wayne Counties form the catchment area for the Clarinda mental health institute.

29.1(3) *Independence.* Allamakee, Benton, Black Hawk, Bremer, Buchanan, Butler, Cedar, Chickasaw, Clayton, Clinton, Delaware, Dubuque, Fayette, Floyd, Grundy, Howard, Iowa, Jackson, Jasper, Johnson, Jones, Linn, Mitchell, Muscatine, Poweshiek, Scott, Tama, and Winneshiek Counties form the catchment area for the Independence mental health institute.

29.1(4) *Mount Pleasant.* Appanoose, Davis, Des Moines, Henry, Jefferson, Keokuk, Lee, Louisa, Lucas, Mahaska, Marion, Monroe, Van Buren, Wapello, and Washington Counties form the catchment area for the Mount Pleasant mental health institute.

29.1(5) *Substance abuse or dual diagnosis treatment.* For the purpose of an adult individual seeking substance abuse or dual diagnosis treatment, the Mount Pleasant catchment area shall include the entire state.

29.1(6) *Adolescent or children's treatment.*

a. For the purpose of treating a minor from the Clarinda catchment area who requires admission or commitment to a mental health institute's adolescent or children's treatment program, the Clarinda catchment area is deemed to be a part of the Cherokee catchment area.

b. For the purpose of treating a minor in the Mount Pleasant catchment area who requires admission or commitment to a mental health institute's adolescent or children's treatment program, the Mount Pleasant catchment area is deemed to be a part of the Independence catchment area.

29.1(7) *Gero-psychiatric services.* For the purposes of an adult individual seeking gero-psychiatric services, the Clarinda catchment area shall include the entire state.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—29.2(218,229) Voluntary admissions.

29.2(1) *Application form.*

a. Any individual who has symptoms of mental illness may apply for voluntary inpatient treatment or voluntary outpatient or day treatment using Form 470-0420, Application for Voluntary Admission to a Mental Health Institute.

b. Any individual requesting substance abuse treatment shall complete Form 470-0425, Application for Voluntary Admission—Substance Abuse.

29.2(2) *Minors.* A parent, guardian, or legal representative of a minor individual may make application for the individual's voluntary admission directly to the mental health institute using Form 470-0420, Application for Voluntary Admission to a Mental Health Institute. When a minor objects to the admission and the chief medical officer of the mental health institute determines that the admission is appropriate, the parent, guardian, or custodian must petition the juvenile court for approval of admission before the minor shall be admitted.

29.2(3) *County approval.* When an adult individual or a person responsible for the individual wishes to apply for voluntary admission and is unable to pay the cost of care, application for admission shall be made to and authorized through the central point of coordination or regional administrator for the individual's county of residence before application for admission shall be made to the mental health institute. Authorization for admission shall be provided by the signature of one or more officially designated agents of the county board of supervisors using Form 470-0420, Application for Voluntary Admission to a Mental Health Institute, before the form is forwarded to the mental health institute.
[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—29.3(229,230) Certification of county of residence.

29.3(1) *Certification data.* By the end of the next working day following a non-Medicaid payment-eligible adult individual's admission, the facility shall send a copy of Form 470-4161, DHS MHI Admission Core Data, by facsimile to the central point of coordination or the regional administrator for the county of admission.

29.3(2) *County response.* For adult cases where the admitting county does not dispute the individual's county of residence, no further response is needed. If the admitting county disputes the applicant's affirmation of county of residence, the county or its officially designated agent shall be responsible for resolving the dispute using the dispute resolution process in Iowa Code section 331.394. If the state disputes the individual's affirmation of county of residence, the state shall be responsible for initiating the dispute resolution process.
[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—29.4(218,230) Charges for care. The rates for cost of hospitalization are established by the division administrator and shall be available by contacting the business manager of the mental health institute that serves the catchment area in which the individual's county of residence is located.

29.4(1) Individuals requesting voluntary admission without going through the central point of coordination or regional administrator process shall be required to pay the cost of hospitalization in advance. This cost shall be computed at 30 times the last per diem rate and shall be collected weekly in advance upon admission. The weekly amount due shall be determined by dividing the monthly rate by 4.3.

29.4(2) The facility shall bill each county for services provided to individuals chargeable to the county during the preceding calendar quarter as required in Iowa Code section 230.20. In determining the charges for services, direct medical services shall include:

a. X-ray services.
b. Laboratory services.
c. Dental services.
d. Electroconvulsive treatment (ECT).
e. Electrocardiogram (EKG).
f. Basal metabolism rate (BMR).
g. Pharmaceutical services.
h. Physical therapy.
i. Electroencephalograph (EEG).
j. Outside physician and hospital services billed to the mental health institutes.
k. Optometric services.
l. Outside ambulance services billed to the mental health institutes.

29.4(3) The liability of a person legally liable for support of an individual with mental illness after 120 days of hospitalization shall be standard for one person in the family investment program as established in 441—subrule 41.28(2).
[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—29.5(229) Authorization for treatment. No individual receiving services, either on a voluntary or involuntary basis, shall be provided treatment other than what is necessary to preserve life or protect others from physical injury unless:

1. The individual has given consent by signing Form 470-0428, Mental Health Institute Agreement and Consent to Treatment;

2. A court has ordered treatment; or

3. The individual's parent, guardian, or legal representative has given consent by signing Form 470-0428, Mental Health Institute Agreement and Consent to Treatment.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—29.6(217,228,229) Rights of individuals. An individual receiving care from a state mental health institute shall have the following rights.

29.6(1) *Information.* An individual receiving care from a state mental health institute shall have the right to:

a. Receive an explanation and written copy of the rules of the facility.

b. Be provided information on the provisions of law pertaining to admission to and discharge from the facility.

c. Receive an explanation of the individual's medical condition and be informed as to treatment plans and the attendant risks of treatment.

d. Be provided with complete and current information concerning the individual's diagnosis, treatment, and progress in terms and language understandable to the individual.

e. Have the information required in this subrule made available to the individual's parent, guardian, or legal representative when it is not feasible to give the information directly to the individual.

29.6(2) *Care and treatment.* An individual receiving care from a state mental health institute shall have the right to:

a. Be evaluated promptly following admission and receive emergency services appropriate to the individual's needs.

b. Have a current individualized written plan of treatment.

c. Receive appropriate treatment, services, and rehabilitation for the individual's mental illness, including appropriate and sufficient medical and dental care.

d. Have the opportunity for educational, vocational, rehabilitative, and recreational programs appropriate to the individual's treatment needs.

e. Have the confidentiality of the individual's personal mental health institute records maintained and have access to those records within a reasonable period.

f. Work, when available and desired and as appropriate to the individual's plan of treatment, and be compensated for that work in accordance with federal and state laws.

g. Have an individualized posthospitalization plan.

29.6(3) *Living conditions.* An individual receiving care from a state mental health institute shall have the right to:

a. Live in the least restrictive conditions necessary to achieve the purposes of treatment.

b. Receive care in a manner that respects and maintains the individual's dignity and individuality.

c. Have opportunities for personal privacy, including during the care of personal needs.

d. Keep and use appropriate personal possessions, including wearing the individual's own clothing.

e. Share a room with a spouse when both live on a long-term basis in the same facility.

f. Be free from unnecessary drugs, restraints, and seclusion except when necessary to protect the immediate health or safety of the individual or others.

g. Be free from physical, psychological, sexual, or verbal abuse, neglect and exploitation.

29.6(4) *Communication.* An individual receiving care from a state mental health institute shall have the right to:

a. Have a family contact or representative of the individual's choice or the individual's community physician notified promptly of the individual's admission.

b. Communicate with people and access services at the facility and in the community, including organizing and participating in resident groups while at the facility.

c. Receive visits of the individual's choice from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team.

d. Communicate and meet privately with persons of the individual's choice without prior notice given to the facility unless the communication is determined inappropriate by the individual's treatment team.

e. Send and receive unopened mail.

f. Make and receive private telephone calls, unless the calls have been determined inappropriate by the individual's treatment team.

g. Access current informational and recreational media such as newspapers, television, or periodicals.

29.6(5) *Self-determination.* An individual receiving care from a state mental health institute shall have the right to:

a. Have a dignified existence with self-determination, making choices about aspects of the individual's life that are significant to the individual.

b. Participate in the development and implementation of the individual's treatment plan.

c. Give informed consent, including the right to withdraw consent at any given time.

d. Refuse treatment (such as medication, surgery or electroconvulsive therapy) offered without the individual's expressed informed consent, and be provided with an explanation of the consequences of those refusals unless treatment is necessary to protect the health or safety of the individual or is ordered by a court.

e. Immediate discharge (if admitted voluntarily) by submitting a written notice to the superintendent or chief medical officer, unless a written request for involuntary hospitalization is submitted to a court.

f. Refuse to perform services for the facility and not be coerced to perform services.

g. Manage the individual's own financial affairs unless doing so is limited under law or determined not appropriate by the individual's treatment team.

h. Choose activities, schedules, and care consistent with the individual's interests, needs, and treatment plans.

i. Engage in social, religious, and community activities of the individual's choice.

j. Formulate advanced directives and be provided care in compliance with these directives.

29.6(6) *Advocacy.* An individual receiving care from a state mental health institute shall have the right to:

a. Exercise the individual's rights as a citizen or resident of the United States.

b. File a grievance pursuant to rule 441—28.4(225C,229) without any intimidation or reprisal resulting from the grievance.

c. Request a judicial review of the hospitalization, file for a writ of habeas corpus, have an attorney of the individual's choice, and communicate and meet privately with the individual's attorney without prior notice given to the facility.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—29.7(218) Visiting.

29.7(1) Visiting hours on Monday through Friday are from 12 noon to 8 p.m. and are from 10 a.m. to 8 p.m. on Saturday, Sunday, and holidays. Visiting hours shall be posted in each facility.

The physician may designate exceptions for special hours on an individual or ward basis. Therapy for the individual shall take precedence over visiting. Visiting shall not interfere with the individual's treatment program or meals.

29.7(2) A visit shall be terminated when behavior on the part of the individual or visitor is disruptive to the individual's treatment plan.

29.7(3) Visiting on grounds shall be permitted when the individual has a grounds pass.

29.7(4) Visitors wishing to take an individual off grounds shall receive prior approval from the attending physician.

29.7(5) All visitors shall obtain a visitor's pass at the switchboard or another area as designated by the superintendent and posted. The pass shall be given to a ward employee before the visitor is allowed on the ward.

29.7(6) Persons under 12 years of age shall not visit on the ward.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

These rules are intended to implement Iowa Code chapters 217, 218, 228, 229, and 230.

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CHAPTER 30
STATE RESOURCE CENTERS

PREAMBLE

This chapter sets policies for the state resource centers listed in Iowa Code section 218.1. These rules apply in addition to the general rules in 441—Chapter 28.

441—30.1(218,222) Catchment areas. The catchment areas for the two state resource centers shall be as follows.

30.1(1) *Glenwood.* Adair, Adams, Appanoose, Audubon, Benton, Carroll, Cass, Cedar, Cherokee, Clarke, Clinton, Crawford, Davis, Decatur, Des Moines, Fremont, Greene, Guthrie, Harrison, Henry, Ida, Iowa, Jefferson, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Lucas, Lyon, Mahaska, Mills, Monona, Monroe, Montgomery, Muscatine, Page, Plymouth, Pottawattamie, Ringgold, Sac, Scott, Shelby, Sioux, Taylor, Union, Van Buren, Wapello, Washington, Wayne, and Woodbury Counties form the catchment area for the Glenwood resource center.

30.1(2) *Woodward.* Allamakee, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Cerro Gordo, Chickasaw, Clay, Clayton, Dallas, Delaware, Dickinson, Dubuque, Emmet, Fayette, Floyd, Franklin, Grundy, Hamilton, Hancock, Hardin, Howard, Humboldt, Jackson, Jasper, Kossuth, Madison, Marion, Marshall, Mitchell, O'Brien, Osceola, Palo Alto, Pocahontas, Polk, Poweshiek, Story, Tama, Warren, Webster, Winnebago, Winneshiek, Worth, and Wright Counties form the catchment area for the Woodward resource center.

This rule is intended to implement Iowa Code section 222.6.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—30.2(218,222) Admission. Express written consent of the individual or the individual's parent, guardian, or legal representative shall be secured before admission.

30.2(1) *Application for an adult.* Applications for the care, treatment, or evaluation of an adult individual by a resource center shall be made through the central point of coordination or the regional administrator for the board of supervisors of the individual's county of residence. Authorization for the submission of the application shall be provided by the signature of one or more officially designated agents for the county board of supervisors.

a. The application shall be made using Form 470-4402, Application for Admission to a State Resource Center, and shall be accompanied by:

(1) Completed Form 470-4403, Resource Center Agreement and Consent for Services, and

(2) Other information specifically requested in writing by the resource center.

b. The application shall be submitted through the division administrator or the division administrator's designee.

30.2(2) *Application for a minor.* Application for a minor individual shall be made through the division administrator or the division administrator's designee using Form 470-4402, Application for Admission to a State Resource Center. The application shall be accompanied by:

a. Completed Form 470-4403, Resource Center Agreement and Consent for Services, and

b. Other information specifically requested in writing by the division administrator or the division administrator's designee.

30.2(3) *Application for readmission.* When the application is for a readmission, the resource center may waive the resubmittal of any information already in the files other than Form 470-4402, Application for Admission to a State Resource Center.

30.2(4) *Receipt of application.* Upon receipt of an application, the resource center may:

a. Provide an individual with outpatient evaluation treatment, training, or habilitation services; or

b. Admit an individual on a temporary basis for either:

(1) A preadmission diagnostic evaluation to determine whether the individual would be appropriate to admit to the regular program, or

(2) A diagnostic evaluation to assist in planning for community-based services or respite care.

30.2(5) *Eligibility for admission.* Eligibility for admission shall be determined by:

a. A preadmission diagnostic evaluation,

b. An established diagnosis of intellectual disability,

c. The availability of an appropriate program, and

d. The availability of space at the facility.

This rule is intended to implement Iowa Code sections 222.13 and 222.13A.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—30.3(222) Non-Medicaid payment-eligible individuals. The cost for the care, as determined in Iowa Code sections 222.73, 222.74, and 222.75, for an individual who is not Medicaid payment eligible shall be the responsibility of the individual's county of residence. All disputes regarding the county of residence of an individual shall be resolved using the dispute resolution process in Iowa Code section 331.394.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09; **ARC 1145C**, IAB 10/30/13, effective 1/1/14]

441—30.4(222) Liability for support. The liability of any person, other than the individual, who is legally bound for the support of any individual under 18 years of age shall be determined in the same manner as parent liability in rule 441—156.2(234), except that the maximum liability shall not exceed the standards for personal allowances established by the department under the family investment program.

This rule is intended to implement Iowa Code section 222.78.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—30.5(217,218,225C) Rights of individuals.

30.5(1) *Information.* An individual receiving care from a state resource center shall have the right to:

a. Receive an explanation and written copy of the rules of the facility.

b. Receive an explanation of the individual's medical condition, developmental status, and behavioral status, and be informed as to treatment plans and the attendant risks of treatment.

30.5(2) *Care and treatment.* An individual receiving care from a state resource center shall have the right to:

a. Receive appropriate treatment, services, and habilitation for the individual's disabilities, including appropriate and sufficient medical and dental care.

b. Have the confidentiality of the individual's personal resource center records maintained and have access to those records within a reasonable period.

c. Work, when available and desired and as appropriate to the individual's plan of treatment, and be compensated for that work in accordance with federal and state laws.

30.5(3) *Living conditions.* An individual receiving care from a state resource center shall have the right to:

a. Receive care in a manner that respects and maintains the individual's dignity and individuality.

b. Have opportunities for personal privacy, including during the care of personal needs.

c. Keep and use appropriate personal possessions, including wearing the individual's own clothing.

d. Share a room with a spouse when both live in the same facility.

e. Be free from unnecessary drugs and restraints.

f. Be free from physical, psychological, sexual, or verbal abuse, neglect and exploitation.

30.5(4) *Communication.* An individual receiving care from a state resource center shall have the right to:

a. Communicate with people and access services at the facility and in the community, including organizing and participating in resident groups while at the facility.

b. Receive visits of the individual's choice from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team.

c. Communicate and meet privately with persons of the individual's choice without prior notice given to the facility unless the communication is determined inappropriate by the individual's treatment team.

d. Send and receive unopened mail.

e. Make and receive private telephone calls, unless the calls have been determined inappropriate by the individual's treatment team.

30.5(5) *Self-determination.* An individual receiving care from a state resource center shall have the right to:

a. Have a dignified existence with self-determination, making choices about aspects of the individual's life that are significant to the individual.

b. Give informed consent, including the right to withdraw consent at any given time.

c. Refuse treatment (such as medication or behavioral interventions) offered without the individual's expressed informed consent, and be provided with an explanation of the consequences of those refusals unless treatment is necessary to protect the health or safety of the individual or is ordered by a court.

d. Refuse to perform services for the facility and not be coerced to perform services.

e. Manage the individual's own financial affairs unless doing so is limited under law or determined not appropriate by the individual's treatment team.

f. Choose activities, schedules, and care consistent with the individual's interests, needs and care plans.

g. Engage in social, religious, and community activities of the individual's choice.

30.5(6) *Advocacy.* An individual receiving care from a state resource center shall have the right to:

a. Exercise the individual's rights as a citizen or resident of the United States.

b. File a grievance pursuant to rule 441—28.4(225C,229) without any intimidation or reprisal resulting from the grievance.

This rule is intended to implement Iowa Code sections 217.30, 218.4, 225C.28A, and 225C.28B.

[**ARC 8094B**, IAB 9/9/09, effective 11/1/09]

441—30.6(218) Visiting.

30.6(1) Individuals are encouraged and shall be able to receive visits from persons of the individual's choice and at times desired by the individual. At the individual's choice, the individual's parents, guardian, or legal representative or other members of the individual's family may visit without prior notice given to the facility.

30.6(2) Visits determined by the individual's treatment to be inappropriate or disruptive to the individual's treatment plan or the health and safety of other individuals may be denied or terminated.

30.6(3) An individual or other person denied visitation may file a grievance through the facility's grievance process.

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CHAPTER 31
CIVIL COMMITMENT UNIT

441—31.1(229A) Definitions.

"Business day" means a working day in the usual Monday-through-Friday workweek. A holiday falling within this workweek shall not be counted as a business day.

"Contraband" means weapons, ammunition, tobacco, alcohol, drugs, money, altered authorized property, mood-altering plant material or chemical, obscene material as defined in Iowa Code section 728.1(5), explosives, material that can be used in the manufacture of explosives, or material advocating disruption of or injury to residents, employees, programs, or physical facilities. "Contraband" includes anything which is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Facility" means the civil commitment unit for sexual offenders.

"Facility administrator" means the person appointed as the administrator of the civil commitment unit for sexual offenders.

"Gift or bequest" means anything of value the facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written complaint by or on behalf of an individual that involves a rights or rule violation or unfairness to the individual.

"Guardian" means the person other than a parent of a child who has been appointed by the court to have custody of the person of the individual as provided under Iowa Code section 232.2(21) or 633.3(20).

"Individual" means a person who has been committed to the civil commitment unit for sexual offenders (CCUSO) under Iowa Code chapter 229A.

"Minor" means a person under the age of 18.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"Support team member" means a person who has agreed to participate in the development and implementation of an individual's relapse prevention plan.

"Visitor" means any person who wishes to visit an individual committed to the facility. "Visitor" does not include the individual's attorney of record, other court-appointed attorneys, retained experts, the ombudsman or government officials, or facility-approved clergy.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on one's self or another.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.2(229A) Visitation. Visitation is considered part of the individual's therapeutic program. Visits are expected to benefit the individual's treatment goals while meeting the security needs of the facility and ensuring the safety of the individual and the visitor.

31.2(1) *Approval of visitor.* All persons wishing to visit a committed individual who is residing at the facility or is in a transition phase shall have prior approval of the facility administrator before a visit shall be permitted.

a. *Questionnaire and background check.* Before being approved to visit, all visitors shall complete a visitor questionnaire and undergo a background check to determine if:

(1) The visitor has been a victim of the individual;

(2) The visitor has a significant criminal background;

(3) The visitor will not hinder the individual's treatment; or

(4) The visitor will be a part of the individual's support team.

b. *Interview.* Upon return of the questionnaire and completion of the background check, an interview shall be conducted with the visitor to determine whether the visitor will be approved.

c. *Minors.* A minor shall not be permitted to visit unless special circumstances exist and the visit is approved by:

(1) The individual's treatment team,

(2) The facility administrator, and

(3) The minor's parent or guardian.

d. *Support team member.* A visitor identified as a support team member shall complete a four-hour training course on being part of a support team before being approved as part of the individual's support team.

e. *Revocation of approval.* Approval of visitors is at the sole discretion of the facility. Approval may be revoked at any time if the facility determines that:

(1) The visitor rules have been violated; or

(2) The visitor presents a threat to security or is a detriment to the individual's treatment.

f. *Approval after revocation.* Once approval is revoked, the person shall be required to reapply for and be approved for reinstatement before being allowed to visit.

31.2(2) *Prior notification.* Visitors shall call the facility at least 24 hours in advance of a planned visit to schedule the visit.

31.2(3) *Visiting hours.*

a. Visits shall be allowed on:

(1) Monday through Friday from 5:30 p.m. to 8:30 p.m.

(2) Saturdays, Sundays, and holidays from 10:30 a.m. to 2 p.m. and from 2:30 p.m. to 8:30 p.m.

b. Visitors shall not be admitted after 7:30 p.m. on weekdays or after 4:30 p.m. on Saturdays, Sundays, and holidays.

31.2(4) *Visitation limits.* Individuals shall be allowed a maximum of three hours' visitation on weekdays and a total of four hours on Saturdays, Sundays, and holidays. The number of days per week the individual may have visits shall be determined by the individual's treatment team based on the individual's treatment level. At the discretion of the facility, the visit may be split between two different periods of the day.

31.2(5) *Search.* All visitors shall be subject to a search before a visit.

a. A visitor shall be required to remove all items from the visitor's pockets and place the items in a locker provided by the facility or take the items to the visitor's vehicle.

b. Visitors shall not be allowed to bring the following items into the secure area of the facility: purses, packages, folders, binders, briefcases, still or video cameras, cell phones, computers, electronic media storage devices, digital or analog recording devices, or any device that can be used to connect to the Internet.

c. Food items may not be brought into the visiting area.

31.2(6) *Visitor rules.* Each approved visitor shall be given a copy of the facility's visitor rules at the beginning of each visit and shall be required to sign an acknowledgement that the visitor has received the rules and understands them. The visitor rules are as follows:

a. The visitor's name shall be on the approved visitors list.

b. The visitor shall provide 24-hour prior notice of the intent to visit.

c. Upon arrival, the visitor shall check in at the facility master control center.

d. A visitor who is 16 years of age or older shall provide a government-issued photo identification document.

e. A minor who is approved as a visitor shall be accompanied at all times by an approved adult visitor.

f. All visitors shall be subject to the rules of the facility.

g. Visitors shall wear clothing appropriate to the security and therapeutic needs of the facility. Prohibited clothing includes: mini-skirts, shorts, muscle shirts, see-through clothing, or halter tops;

clothing or accessories with obscene words, symbols, or pictures; and clothing with gang colors or symbols.

h. For the duration of the visit, visitors shall be required to remove outerwear such as, but not limited to, coats, hats, gloves, and sunglasses. A medical need for sunglasses for protection from normal interior light shall be verified by a physician's prescription.

i. Smoking shall not be permitted in the facility or on the grounds of the facility except in an enclosed private vehicle.

j. A visitor shall not schedule a visit when the visitor has a communicable disease.

k. Visitors shall not be under the influence of drugs or alcoholic beverages.

l. Food gifts or other items shall not be brought into the facility unless prior approval has been received from the treatment program supervisor. Food items may be purchased from vending machines at the facility.

m. All visits shall be monitored by an employee.

n. The door to the visiting room shall remain open at all times.

31.2(7) *Denial of visit.* All visitors are subject to denial of a visit each time the visitor enters the facility. Visits can be denied by any employee with reason. Reasons for denial include but are not limited to:

a. The visitor's name is not on the approved visitors list.

b. The visitor did not provide notice of the visit at least 24 hours in advance.

c. The visitor's clothing does not conform to the facility visitor rules.

d. The visitor does not agree to be searched.

e. The visitor is trying to bring contraband into the facility.

f. The visitor is or appears to be under the influence of drugs or alcoholic beverages.

g. The visitor exhibits disruptive behavior that threatens the safety or security of the facility, individuals, employees, or other visitors.

h. The visitor appears to have a health condition that could threaten the health of individuals, employees, or other visitors.

i. The individual has been placed on restrictions for a rule infraction.

j. The number of staff available is inadequate to supervise the visit.

31.2(8) *Termination of visit.*

a. The facility may terminate a visit at any time when:

(1) The visitor or the individual violates any visitor rule during the visit.

(2) Because of the actions of an individual or a visitor, a facility employee becomes concerned about the safety and security of the facility, the individual, the visitor, or other visitors.

(3) The individual's treatment team determines that the visit is counter-therapeutic or is disruptive to the safety and security of the facility.

(4) A crisis in the facility results in an inadequate number of staff available to supervise the visit.

b. The facility may either terminate the current visit or, at the discretion of the individual's treatment team, remove the visitor's name from the approved visitors list.

31.2(9) *Visits outside the facility.* Individuals may visit family and friends outside of the facility when the visit meets all of the following criteria:

a. The visit occurs in connection with a death or life-threatening illness in the family.

b. The visit receives the approval of the facility administrator. Such approval shall be granted only when:

(1) The facility has determined the individual to be a "low escape risk,"

(2) The visit will provide a treatment benefit to the individual with no harmful effects on the individual's family or community, and

(3) The individual pays all expenses associated with supervision of the visit, including facility expenses such as employee wages and transportation costs.

c. The visit is ordered by the court.

31.2(10) *Hospital visits.* Individuals hospitalized in a community facility may have visitors during the hospitalization provided that:

a. The visit does not interfere with the treatment of the individual.

b. The visitor is approved as provided in subrule 31.2(1) unless an exemption is granted by the facility administrator.

c. The visitor is subject to a search as provided in subrule 31.2(5).

d. The visitor is subject to the visitor rules as provided in subrule 31.2(6).

e. The visit may be terminated at the will of the facility as provided in subrule 31.2(8).

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.3(229A) Group visitation. Groups of persons from the general public who wish to visit the facility shall submit a written request and shall be subject to the same security review process as all other visitors.

31.3(1) *Request to visit.* A group wishing to visit the facility shall submit a written request to the facility administrator at least one month in advance of the requested visit. The request shall state the purpose of the visit and the expected therapeutic benefit for the individuals.

31.3(2) *Visitor questionnaire.* Each person in the group shall complete a visitor questionnaire and shall undergo a background check to determine if:

a. The person has been a victim of the individual;

b. The person has a significant criminal background;

c. The person will not hinder the individual's treatment; or

d. The person will be a part of the individual's support team.

31.3(3) *Visitor interview.* Upon return of the questionnaire and completion of the background check, an interview shall be conducted with each person in the group to determine:

a. Whether or not the visit will be authorized; and

b. The location, date, time, and duration of an authorized visit.

31.3(4) *Orientation.* Before entering the facility, a visitor group shall be provided with an introduction and orientation to facility security procedures and to visitor rules that the group will be expected to follow. Each member of the group shall sign a form acknowledging receipt of the visitor rules.

31.3(5) *Denial or termination of visit.* At the discretion of the facility, the entire group or a member of the group may be denied visitation as provided in subrule 31.2(7) or may have the visit terminated as provided in subrule 31.2(8).

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.4(229A) Grievances. Any individual who believes the individual's rights have been violated or who has a complaint concerning the individual's treatment may file a grievance using a form approved by the facility administrator. The individual's family or guardian may file a grievance on behalf of the individual by submitting the grievance in writing to the facility administrator.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.5(229A) Photographing and recording individuals.

31.5(1) *Visitors.* Visitors shall not be allowed to bring any camera or video or audio recording devices into the facility. An individual who wants to have a photograph taken with a visitor shall request prior permission from the individual's treatment team and make arrangements for paying the cost of the photograph.

a. With approval of the treatment team, a facility employee will take the photograph using facility equipment. The facility shall provide the photograph to the individual requesting it. The individual shall be responsible for distribution of the photograph.

b. The facility shall not be liable for any further use or distribution of the photograph made by the individual or by anyone else who comes into possession of the photograph.

31.5(2) *Public media.* Photographs and video and audio recordings by public media inside of the facility and of individuals shall be permitted only with the prior authorization of the facility administrator and of the individual or the individual's guardian.

a. For security or confidentiality of other individuals, the facility administrator may limit the scope of what is photographed or recorded.

b. Public media representatives authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the individual and to preclude the exploitation or embarrassment of the individual.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.6(229A) Release of information.

31.6(1) *Release to news media.* The facility administrator shall be responsible for the release to the news media of information pertaining to the facility. Authority for dissemination and release of information may be designated to other employees at the discretion of the facility administrator.

31.6(2) *Release of confidential information.* Information concerning individuals currently or formerly at the facility which is defined by statute as confidential shall not be released to a person, agency or organization that is not authorized by law to have access to the information unless the individual authorizes the release. Authorization may be given by using Form 470-3951, Authorization to Obtain or Release Health Care Information.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.7(229A) Communication with individuals.

31.7(1) *Incoming telephone calls.*

a. The individual's treatment team shall determine an approved caller list for each individual based on the individual's request for approval. Incoming calls shall not be approved from a person who:

(1) Has been a victim of the individual,

(2) Is a registered sex offender, or

(3) Has been determined by the individual's treatment team as a person whose communication is counter-therapeutic to the individual's treatment plan.

b. All incoming calls for an individual shall require the approval of the facility administrator or designee before the caller will be connected with the individual to determine if the caller is:

(1) On an individual's approved caller list, or

(2) An attorney representing the individual. An attorney representing the individual shall have the right to call the individual at any reasonable time.

c. Approved incoming calls shall not be monitored.

d. The individual has the right to grieve any adverse decision.

31.7(2) *Attorney contacts.* An individual's attorney shall have the right to visit or have telephone contact with the individual at any reasonable time. The individual shall have the right to call the individual's attorney during normal business hours and at other times with the consent of the attorney. The individual or the attorney shall be responsible for any costs associated with the call.

31.7(3) *Interviews.* Interviews of an individual by the news media or other outside persons or groups shall be permitted only with the prior consent of the individual or the individual's guardian.

a. All requests for an interview shall be made to the facility administrator. When a request is received, the facility administrator or designee shall:

(1) Notify the individual or the individual's guardian of the request; and

(2) Document notification to the individual or guardian in the individual's record.

b. The individual or the individual's guardian shall be free to decide whether an interview is granted.

c. The facility administrator shall determine how, when, and where the interview is to be done, as necessary to maintain the security of the facility.

31.7(4) *Mail and packages.*

a. Correspondence shall not be permitted between an individual and a victim of the individual, a registered sex offender, or another individual residing at the facility.

b. Correspondence an individual receives from the state ombudsman shall be delivered to the individual unopened. Other outgoing and incoming letters and packages shall not be censored or tampered with in any manner except that an employee may:

(1) Open, but not read, incoming and outgoing letters and packages in the presence of the individual to whom the letters and packages belong; or

(2) Require the individual to open the letters or packages in an employee's presence and disclose the contents.

c. In situations where the employee has reasonable suspicion that a letter or package contains information or materials that threaten the security or the therapeutic needs of the facility, such as but not limited to contraband, threats, escape plans, or sexually explicit content, the correspondence may be read in the presence of the individual.

d. Letters or packages found to contain contraband shall be confiscated. Both the sender and the intended receiver of the confiscated letters and packages shall be notified and given the reasons for the action in writing within two business days of the action.

e. The facility administrator or designee may terminate correspondence between an individual and another person when the individual's treatment team has determined that the correspondence is not in the individual's best interest, is detrimental to the individual's treatment plan, is a threat to public or individual safety, or is a threat to the security of the facility. Termination shall be based on the circumstances of each case.

(1) The facility administrator or designee shall provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.8(229A) Building and grounds. The facility's building and grounds shall not be available for general public use.

This rule is intended to implement Iowa Code chapter 229A.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.9(8,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the facility administrator.

31.9(1) *Evaluation.* The facility administrator or designee shall evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

31.9(2) *Acceptance.* The facility administrator shall be responsible for accepting the gift or bequest and reporting it to the division administrator.

a. All monetary gifts or bequests shall be acknowledged in writing to the donor.

b. All gifts or bequests, regardless of value, shall be reported to the Iowa ethics and campaign disclosure board within 20 days of receipt of the gift or bequest using the board's Form-GB.

This rule is intended to implement Iowa Code section 8.7.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

441—31.10(229A) Cost of care. The facility shall seek to recover the full cost or a portion of the cost of care from the individual or another responsible person. The cost of the individual's care shall be determined for each fiscal year included in the length of stay using the average per diem cost multiplied by the total number of days of care.

31.10(1) *Social security benefits.* The facility shall seek recovery from the individual when the individual receives a benefit pursuant to the Social Security Act. In such case, the individual shall be allowed to retain for personal use an amount equal to the personal allowance amount established by the Social Security Administration.

31.10(2) *Other income.* The facility shall seek recovery from the individual when the individual has other income; a trust fund; individually owned real estate, stocks, bonds, savings account, checking account, or certificate of deposit; an individual retirement account; or proceeds from the disposal of real estate or other property.

31.10(3) *Other person legally liable.* The facility shall seek recovery from a person who is legally liable for the support of the individual up to the amount of the person's legal liability. The facility shall seek recovery from a person who is bound by contract to support the individual up to the amount of the contract. A person legally liable to support the individual shall not include a political subdivision.

This rule is intended to implement Iowa Code section 229A.12.

[**ARC 9646B**, IAB 8/10/11, effective 10/1/11]

[Filed ARC 9646B (Notice ARC 9481B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]

[Prior to 7/1/83, Social Services[770] Ch 32]
[Prior to 2/11/87, Human Services[498]]

CHAPTER 32
STATE COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION SERVICES FUND AND SPECIAL NEEDS GRANTS

[Prior to 7/1/83, Social Services[770] Ch 32]
[Prior to 2/11/87, Human Services[498]]

Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 33
COMMUNITY MENTAL HEALTH CENTER STANDARDS

Rescinded 9/29/93 IAB, effective 12/1/93; see 441—Chapter 24, Divisions I, III.

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

[Prior to 8/18/82, Mental Health Advisory Council[566] Ch 2]
[Prior to 7/1/83, Social Services[770] Ch 34]
[Prior to 2/11/87, Human Services[498]]

441—34.1(225C) Definitions. Unless otherwise indicated, the following definitions shall apply to the specific terms used in these rules:

"Alternative diagnostic facility" means any organization or individual designated by the county board of supervisors to implement the preliminary diagnostic evaluation policy (Iowa Code section 225C.14) when a county is not served by a community mental health center capable of the diagnostic evaluations. An alternative diagnostic facility may be the outpatient service of a state mental health institute or any organization or individual able to furnish the requisite skills and to meet the standards set forth in this chapter by the mental health and mental retardation commission.

"Mental health professional" means a person who:

1. Holds at least a master's degree in a mental health field, including, but not limited to, psychology, counseling and guidance, nursing and social work; or is a doctor of medicine (M.D.) or doctor of osteopathic medicine and surgery (D.O.); and
2. Holds a current Iowa license when required by Iowa licensure law; and
3. Has at least two years of postdegree experience, supervised by a mental health professional, in assessing mental health problems and needs of individuals and in providing appropriate mental health services for those individuals.

"Preliminary diagnostic evaluation" means an assessment of a person's mental health problems and needs in order to determine the most appropriate service for the person. The evaluation includes, but is not limited to, an assessment of the individual's needs, abilities, disabilities, and relevant environmental factors. Where possible, there is collaboration with the individual's family or significant others as appropriate.

441—34.2(225C) Function. An alternative diagnostic facility shall:

34.2(1) Perform a preliminary diagnostic evaluation of a person who is being considered for admission to a state mental health institute on a voluntary basis pursuant to Iowa Code chapter 229 in order to:

a. Confirm that admission of the person to a state mental health institute is appropriate to the person's mental health needs, and that no suitable alternative method of providing the needed services in a less restrictive setting, in or nearer to the person's home community, is currently available. When results of the evaluation indicate that admission to the mental health institute is appropriate, the evaluator shall inform the institute of the results.

b. Confirm that admission to a state mental health institute is not appropriate to the person's mental health needs. When results of the evaluation indicate that a treatment program, other than that of a state mental health institute, is more appropriate, and the individual agrees, the evaluator shall make arrangements with the alternative program to accept the referral.

34.2(2) Assist the court and, insofar as possible, provide or designate a physician to perform a prehearing examination of a respondent required under Iowa Code section 229.8, subsection 3, paragraph *"b."*

441—34.3(225C) Standards. In order to be designated as an alternative diagnostic facility, a facility shall meet the following standards:

34.3(1) The facility shall have clearly defined lines of authority and accountability so that a contractual agreement may be entered into with a county for the provision of preliminary diagnostic evaluations.

34.3(2) The preliminary diagnostic evaluation shall be performed by a mental health professional within a reasonable time frame, not to exceed 48 hours.

34.3(3) The mental health professional shall be familiar with the mental health institute serving the area and with the treatment resources of the community served.

34.3(4) The facility shall have written procedures for timely reporting of results of evaluations to the selected treatment resource.

34.3(5) The facility shall have written policies and procedures to safeguard the consumer's right to treatment, confidentiality, and freedom of choice. The policies and procedures shall be in conformance with federal and state laws and rules.

34.3(6) The facility shall have written procedures for fees for services.

34.3(7) The facility shall comply with procedures for uniform reporting of statistical data as established by the division of mental health, mental retardation, and developmental disabilities.

34.3(8) The facility shall comply with the standards for the maintenance and operation of public and private facilities offering services to mentally ill persons as adopted by the mental health and mental retardation commission.

These rules are intended to implement Iowa Code sections 225C.4 and 225C.17.

[Filed 9/26/80, Notices 3/19/80, 8/6/80—published 10/15/80, effective 11/19/80[1]]

[Filed emergency 7/22/82—published 8/18/82, effective 7/22/82]

[Filed 12/17/82, Notice 10/13/82—published 1/5/83, effective 2/9/83]

[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[1] As Agency 566—Chapter 2

CHAPTER 35
SUPPLEMENTAL EXPENSE PAYMENT

Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

PREAMBLE

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

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

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

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

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

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

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

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

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

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

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

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

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

441—36.5 Reserved.

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

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

PREAMBLE

These rules describe the nursing facility quality assurance assessment authorized by Iowa Code chapter 249L. The rules explain how the assessment is determined and paid.

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

441—36.6(249L) Assessment.

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

a. Nursing facilities operated by the state.

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

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

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

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

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

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

d. All other nursing facilities are required to pay a quality assurance assessment of $5.26 per non-Medicare patient day.

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

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

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

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

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

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

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

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

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

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

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

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

441—36.8 and **36.9** Reserved.

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

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

PREAMBLE

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

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

441—36.10(249M) Application of assessment.

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

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

a. Contractual adjustments,

b. Charity care,

c. Bad debt,

d. Medicare revenue, or

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

(1) Nonoperating revenue,

(2) Other operating revenue,

(3) Skilled nursing facility revenue,

(4) Physician revenue, and

(5) Long-term care revenue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CHAPTER 37
STANDARDS FOR THE CARE OF AND SERVICES TO COUNTY CARE FACILITY RESIDENTS WITH MENTAL ILLNESS AND MENTAL RETARDATION

Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

Pursuant to the Developmental Disabilities and Bill of Rights Act, 42 U.S. Code, Section 6000, et seq., (DD Act) and Iowa Code section 225C.3, the department of human services has been designated as the administering agency to receive the federal assistance to the state developmental disabilities councils from the federal administration on developmental disabilities. These funds are used by the governor's developmental disabilities council.

The purpose of this chapter is to define and structure funding of projects by the governor's developmental disabilities council (also known as the governor's DD council). Projects are designed to influence change in the system of services and supports in Iowa to increase the independence, productivity, and community integration of people with developmental disabilities.

Funding priorities for projects are established by the governor's DD council in the state plan.

441—38.1(225C,217) Definitions.

"Department" means the Iowa department of human services.

"Developmental disability" means a severe, chronic disability of a person 5 years of age or older which is attributed to a mental or physical impairment or a combination of mental and physical impairments, is manifested before the person attains the age of 22, is likely to continue indefinitely, substantially limits the person's ability to carry out major life activities in at least three of the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency, and reflects an ongoing need for individualized, coordinated services. The term, when applied to infants and children from birth to the age of 5, means a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

"Director" means the director of the department or successor agency.

"Governor's DD council" means the governor's developmental disabilities council.

"Projects" means activities designed to address the priority areas as established in the DD Act through any of the following:

1. Activities to increase the capacities and resources of public and private nonprofit entities and others to develop a system for providing specialized services or special adaptations of generic services or other assistance which responds to the needs and capabilities of people with developmental disabilities and their families and to enhance coordination among entities.

2. The conducting of studies and analyses; gathering of information; development of model policies and procedures; and presentation of information, models, findings, conclusions and recommendations to federal, state and local policymakers, in order to enhance opportunities for people with developmental disabilities, including the enhancement of a system for providing or making available specialized services or special adaptations of generic services for people with developmental disabilities and their families.

3. The demonstration of new ways to enhance the independence, productivity and integration into the community of people with developmental disabilities, such as model demonstrations which, if successful, will be made generally applicable through sources of funding other than funding under the DD Act, including new ways to enhance specialized services or special adaptations of generic services for people with developmental disabilities and their families.

4. Outreach activities for people with developmental disabilities to enable them to obtain assistance in the priority areas established in the state plan, including access to specialized services or special adaptations of generic services for people with developmental disabilities and their families.

5. Training for people with developmental disabilities, their family members, and personnel, including professionals, paraprofessionals, students and volunteers on obtaining access to, or on providing, services and other assistance in the area, including specialized services or special adaptations of generic services for people with developmental disabilities and their families.

6. Similar activities designed to prevent developmental disabilities from occurring or to expand and enhance the independence, productivity and integration into the community of people with developmental disabilities through the state on a comprehensive basis.

"State plan" means the document required under the DD Act describing goals, objectives and funding priorities.

441—38.2(225C,217) Program eligibility. For any year in which Congress appropriates funds, the governor's DD council shall, consistent with the state plan and the priorities established under the DD Act, determine projects to fund under the developmental disabilities basic state grant program. Funding priorities will be established by the governor's DD council in the state plan and will be consistent with the priorities established in the DD Act. (Applications for capital expenditures or capital renovations are not eligible for funding.) The governor's DD council may award funding through any of the following processes: competitive, sole source, or unsolicited proposals.

441—38.3(225C,217) Application under competitive process.

38.3(1) *Contract cycle.* The governor's DD council and director will announce, through public notice, the openings of an application period for projects. Applicants for contracts shall submit first a letter of intent and then a proposal by deadlines specified in the announcement. Exceptions to the application process may be granted and shall be specified in the public notice.

38.3(2) *Letter of intent.* The letter of intent must clearly identify the applicant and specify the category or service to be addressed in the project. Only letters of intent received by the deadline specified in the public notice will be considered. Applicants will be given a written acknowledgment of their letter of intent and an application packet.

38.3(3) *Proposal.* Applicants shall submit the proposal to the governor's DD council on Form 470-2366, "Developmental Disabilities Application Package." If a proposal does not contain the information specified in the application package or if it does not arrive by the due date specified in the announcement, it will be disapproved.

If additional application information is viewed as necessary by the council, it will be specified in the application packet.

441—38.4(225C,217) Competitive project awards.

38.4(1) *Review of proposals.* All proposals meeting the minimum criteria above shall be evaluated by a governor's DD council committee, council staff, and other members of the council as deemed necessary. The council may use advisory groups, committees, and other persons with expertise in evaluating proposals. The criteria upon which all reviews will be based shall be contained in the application package, Form 470-2366. The committees shall make recommendations for project funding to the entire governor's DD council for consideration. The governor's DD council's decision shall be forwarded to the director. The director shall enter into contracts.

38.4(2) *Selection of proposals.* Proposals shall be selected using criteria and other information as specified in the application package, Form 470-2366.

a. Points shall be awarded for criteria as follows:

(1) Up to 28 points shall be given for applicant capability which includes demonstrating consumer-driven values, direction and influence, evidence of related experience and knowledge, sufficient personnel and other resources, and linkages with others needed to complete the project.

(2) Up to 60 points shall be given for the workplan, with up to 15 of those points being earned for measurable goals and objectives, up to 15 points for action steps, up to 15 points for evaluation activities, and up to 15 points for product or outcome dissemination strategies.

(3) Up to 12 points shall be given for financial information, including line item budget and justification that relates to the objectives of the project.

b. In addition to the criteria in the application package, Form 470-2366, the governor's DD council may consider other information which may include, but need not be limited to, past products developed

and projects completed by the applicant. Any additional information to be considered shall be specified in the application package.

38.4(3) *Rejection of proposals.* The governor's DD council may reject any or all proposals on the basis of funds available or quality of applications.

441—38.5(225C,217) Sole source or emergency selection project awards. The governor's DD council may, within specific project parameters under Executive Order Number 50 and department of revenue preaudit procedures, elect to award a contract under the sole source or emergency option.

38.5(1) *Justification for sole source selection.* Sole source selection procedures may be justified when one of the following conditions exists:

a. Only a single source is determined to be qualified or eligible, or is obviously the most qualified or eligible to perform the services.

b. The work is of such a specialized nature or related to a specific geographical location, that a single source by virtue of its experience, expertise, or proximity to the project could most satisfactorily complete the work.

c. Sole source selection shall automatically apply to contracts under $1,000, plus allowable travel expenses. Competitive bids are not required for contracts under $1,000.

38.5(2) *Justification for emergency selection.* Emergency selection procedures may be justified when it is determined that normal selection procedures would unduly delay the initiation of critically needed work or impose unjustifiable costs on the governor's DD council.

38.5(3) *Approval for sole source or emergency selection.* Sole source or emergency selection shall be approved by the director or director's designee. The justification for use of sole source or emergency selection and the basis upon which a particular source is selected shall be documented in the contract file.

441—38.6(225C,217) Field-initiated proposals. The governor's DD council may consider field-initiated requests and proposals that elicit support for specific projects, research, planning or advocating activities for people with developmental disabilities. The field-initiated proposals shall be in one of the following areas:

38.6(1) *Cosponsorships.* The governor's DD council may designate a portion of its funds to cosponsor activities of other organizations and agencies.

a. Cosponsorships may include, but need not be limited to, endorsements, materials and supplies, and funds for conferences, seminars, training, workshops, and supports to assist people with developmental disabilities or family members to be involved in these activities.

b. The governor's DD council, in cooperation with the department, will announce through public notice the availability of funds designated for cosponsorships.

c. A letter of request for cosponsorship shall be submitted. The information to be included and the deadline for submission shall be specified in the public notice.

d. All requests shall be reviewed by council staff or a standing committee of the council which shall submit a recommendation to the council for final action.

38.6(2) *Projects.*

a. The governor's DD council may consider ideas for specific projects from outside its planning process. Proposals pertinent to the priority areas may be referred to the appropriate committee for possible request for proposal (RFP) activities during the next funding cycle.

b. The governor's DD council may designate a portion of its funding in support of project proposals from the field. Proposals will be reviewed under the same process outlined in rules 441—38.3(225C,217) and 441—38.4(225C,217).

441—38.7(225C,217) Notification. Notification of acceptance or denial of the proposal will be sent to each applicant. The date of notice of decision will be specified in the public notice.

441—38.8(225C,217) Request for reconsideration. Dissatisfied applicants may file a request with the director for reconsideration of a decision. The request for reconsideration must be submitted within ten

working days of the date of the notice of decision and must include a request for the director to review the decision and the reasons for dissatisfaction. Within ten working days of the receipt of the request the director or designee will review the request and evidence provided and will issue a written final decision outlining the reasons for that decision.

No disbursements will be made to any applicant for a period of ten working days after the date of the notice. If a request is received within the ten working days, all disbursements will be held pending a final decision on the request. All applicants involved will be notified if a request is filed.

441—38.9(225C,217) Contracts. The funds for approved projects will be awarded through a contract entered into by the director and the applicant. The work statement of the contract and the budget will be mutually negotiated between the director or designee and the applicant. The contract may cover a period not to exceed 24 months. The contract shall set forth the expectations and terms of compliance between the contractor and the director.

441—38.10(225C,217) Records. Rescinded IAB 7/7/93, effective 9/1/93.

441—38.11(225C,217) Reallocation of funds. The contractor shall report, in writing, any projected underexpenditures prior to the completion of the contract. When underexpenditures are reported, the director or designee may renegotiate the total contract budget to avoid underexpenditure.

441—38.12(225C,217) Conflict of interest policy. All governor's DD council members and those serving in an advisory capacity to the governor's DD council as defined in 441—1.7(8)*"c"*(2) shall not engage in activities that present a conflict of interest.

38.12(1) Governor's DD council members and those serving in an advisory role to the governor's DD council are prohibited from applying for any project when they were involved in recommending the project, or designing or developing the request for proposal.

38.12(2) All governor's DD council members and those serving in an advisory capacity to the governor's DD council who serve or whose family members serve as officers, directors, partners, consultants, or employees of the applicant being evaluated shall be excluded from preliminary review of proposals, discussing with governor's DD council members who will be voting, and advising or voting on the evaluation of that applicant and all other applicants submitting proposals in that category.

These rules are intended to implement Iowa Code sections 217.6 and 225C.3.

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CHAPTER 39
MENTAL ILLNESS SPECIAL SERVICES FUND

Rescinded IAB 10/15/03, effective 12/1/03

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

[Prior to 7/1/83, Social Services[770] Ch 40]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—40.1 to **40.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—40.1(239) to 40.9(239)]

441—40.21(239B) Definitions.

"Applicant" means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child(ren).

"Assistance unit" includes any person whose income is considered when determining eligibility or the family investment program grant amount.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the family investment program.

"Income in kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

Whenever *"medical institution"* is used in this title, it shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals
2. Extended care facilities (skilled nursing)
3. Intermediate care facilities
4. Mental health institutions
5. Hospital schools

"Needy specified relative" means a nonparental specified relative, listed in 441—subrule 41.22(3), who meets all the eligibility requirements to be included in the family investment program.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Payment month" means the calendar month for which assistance is paid.

"Payment standard" means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program" means the department's work and training program as described in 441—Chapter 93.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Qualified alien" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is admitted to the United States as an Amerasian as described in 8 U.S.C. Section 1612(b)(2)(A)(ii)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c); or
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

"Qualifying quarters" means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act that were worked by a parent of an alien while the alien was under the age of 18 and all of the qualifying quarters that were worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

"Recipient" means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.22(3) who is receiving assistance for the child(ren). Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Standard of need" means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent, by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5, and 239B.6.

[**ARC 9439B**, IAB 4/6/11, effective 6/1/11]

441—40.22(239B) Application. The application for the family investment program shall be submitted on the Financial Support Application, Form 470-0462 or Form 470-0462(S). The application shall be signed by the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and attest to the information for the assistance unit.

40.22(1) Each individual wishing to do so shall have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.22(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.22(3) 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 forms in the next outgoing mail.

40.22(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.22(5) Reinstatement.

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished, or the family meets the conditions described at 441—subparagraph 41.30(3)*"f"*(9). EXCEPTION: The reinstatement provisions of subrule 40.22(5) do not apply when assistance is canceled due to the imposition of a subsequent limited benefit plan as described at 441—subrule 41.24(8), unless the limited benefit plan is stopped as described in 441—paragraph 41.24(8)*"g"* or *"h."*

b. When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date all information required to establish eligibility is provided.

c. When assistance has been canceled for failure to return a completed review form pursuant to subrule 40.27(3), assistance shall be reinstated without a new application if the completed form is received by the department within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date the Review/Recertification Eligibility Document is received.

d. When assistance has been canceled for failure to complete a required review interview, assistance shall be reinstated without a new application if the interview is completed and all necessary information to determine eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility is reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date the interview is completed.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—40.23(239B) Date of application. The date of application is the date an identifiable Financial Support Application, Form 470-0462 or Form 470-0462(S), is received by the department. 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.

40.23(1) The date of application is also the date an identifiable application is received by a designated worker who is in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center or other facility will forward the application to the department office that is responsible for the completion of the eligibility determination.

40.23(2) An identifiable application is an application containing a legible name and address that has been signed.

40.23(3) A new application is not required when adding a person to an existing eligible group. 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 the date of the report.

a. In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the date of application to add the person is the date the person indicated willingness to cooperate.

b. EXCEPTIONS:

(1) When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the date of application to add the person is the date the social security number or proof of application for a social security number is provided.

(2) When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.23(5) or 41.25(5) or rule 441—46.29(239B), the date of application to add the person is the first day after the period of ineligibility has ended.

(3) When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the date of application to add the person is the date the person signs a family investment agreement.

40.23(4) Grace period.

a. When an application has been denied for failure to provide requested information, if all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date all of the information is provided.

b. When an application has been denied for failure to attend an interview, if the interview is completed and all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date the interview is completed or the date all of the information is provided, whichever is later.

This rule is intended to implement Iowa Code section 239B.2.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—40.24(239B) Procedure with application.

40.24(1) The decision with respect to eligibility shall be based primarily on information furnished by the applicant.

a. The applicant shall report no later than at the time of the interview any change as defined at 40.27(4)*"e"* that occurs after the application was signed. Any change that occurs after the interview shall be reported by the applicant within five days from the date the change occurred.

b. The department shall notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources shall serve as a basis for denial of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

(1) Five working days shall be considered as a reasonable period for the applicant to supply the required information or verification. The department shall extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so.

(2) "Supply" shall mean the requested information is received by the department by the specified due date. Any time taken beyond the required time frame shall be considered a delay on the part of the applicant.

c. When an individual is added to an existing eligible group, the five-day requirement for reporting changes shall be waived. These individuals and eligible groups shall be subject to the recipient's ten-day reporting requirement as defined in 40.27(4).

40.24(2) The department or the designated worker as described in subrule 40.23(1) shall conduct a face-to-face or telephone interview with the applicant before approval of the application for assistance.

a. The worker shall assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance.

b. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

(1) When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

(2) When the applicant requests a home visit for the purpose of completing a pending application.

c. When adding an individual to an existing eligible group, the interview requirement may be waived.

40.24(3) Rescinded IAB 1/14/09, effective 2/1/09.

40.24(4) The decision with respect to eligibility shall be based on the applicant's eligibility or ineligibility on the date the department enters all eligibility information into the department's computer system, except as described in subrule 40.24(3). The applicant shall become a recipient on the date all eligibility information is entered into the department's computer system and the computer system determines the applicant is eligible for aid.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.

[**ARC 7740B**, IAB 5/6/09, effective 6/10/09; **ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—40.25(239B) Time limit for decision. A determination of approval or denial shall be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility or ineligibility. This time standard shall apply except in unusual circumstances, such as when 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 expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the department, eligibility will not be established within the 30-day limit, the application shall be approved pending a determination of eligibility.

This rule is intended to implement Iowa Code sections 239B.3, 239B.4, 239B.5 and 239B.6.

441—40.26(239B) Effective date of grant. New approvals shall be effective as of the date the applicant becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual shall be added effective as of the date the individual becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance shall be no earlier than the date of entry or seven days following the date of report, whichever is later.

When the change is timely reported as described at subrule 40.27(4), a payment adjustment shall be made when indicated. When the individual's presence is not timely reported as described at subrule 40.27(4), excess assistance issued is subject to recovery.

In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the effective date of eligibility shall be seven days following the date the person indicated willingness to cooperate. However, in no instance shall the person be added until cooperation has actually occurred.

EXCEPTIONS: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the effective date of eligibility shall be seven days following the date that the social security number or proof of application for a social security number is provided.

When adding a person who was previously excluded from the eligible group as described at 441—subrules 41.23(5), 41.25(5) and 46.28(2) and rule 441—46.29(239B), the effective date of eligibility shall be seven days following the date that the period of ineligibility ended.

When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the effective date of eligibility shall be seven days following the date the person signs a family investment agreement. In no case shall the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described at 441—paragraph 41.24(8)*"a."*

This rule is intended to implement Iowa Code section 239B.3.

441—40.27(239B) Continuing eligibility.

40.27(1) Eligibility factors shall be reviewed at least every six months for the family investment program. An interview may be conducted at the time of a review.

40.27(2) A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—40.21(239B)), or

b. A change in the recipient's circumstances comes to the attention of a staff member.

40.27(3) Information for semiannual reviews shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED).

a. The department shall supply the review form to the recipient as needed or upon request. The department shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

b. When the client has completed Form 470-0462 or Form 470-0462(S), Financial Support Application, for another purpose, this form may be used as the review document.

c. The review form shall be signed by the payee, the payee's authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee's behalf.

40.27(4) Responsibilities of recipients. For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant.

b. The recipient shall complete the required review form when requested by the department in accordance with subrule 40.27(3). Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated and accompanied by verification as required in 441—paragraphs 41.27(1)*"i"* and 41.27(2)*"h."*

c. The recipient has the primary responsibility for providing information and verification needed to establish eligibility and the amount of the family investment program grant. The recipient shall supply, insofar as the recipient is able, information and verification needed within ten working days from the date a written request is mailed by the department to the recipient's current mailing address or given to the recipient. The department shall extend the deadline when the recipient requests an extension because the recipient is making every effort to supply the information or verification but is unable to do so.

(1) "Supply" shall mean that the requested information or verification is received by the department by the specified due date.

(2) When the recipient is unable to furnish information or verification needed to establish eligibility and the amount of the family investment program grant, the recipient shall request assistance from the department.

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

d. The recipient or applicant shall cooperate with the department when the recipient's or applicant's case is selected by quality control for verification of eligibility. The recipient or applicant shall also cooperate with the front end investigations conducted by the department of inspections and appeals to determine whether information supplied to the department by the client is complete and correct regarding pertinent public assistance information unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family investment program eligibility. (See department of inspections and appeals rules 481—Chapter 72.) Failure to cooperate shall serve as a basis for cancellation or denial of the family's assistance. Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

e. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

(1) Beginning or ending income, including receipt of a nonrecurring lump sum.

(2) Resources.

(3) Members of the household.

(4) School attendance of a child.

(5) Mailing or living address.

(6) Receipt of a social security number.

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

(1) The receipt of resources or income or the date income ended.

(2) The date the address changes.

(3) The date the child is officially dropped from the school rolls.

(4) The date a person enters or leaves the household.

(5) The receipt of a social security number.

g. When a change is not timely reported, any excess assistance paid shall be subject to recovery.

40.27(5) After assistance has been approved, eligibility for continuing assistance and the amount of the grant shall be effective as of the first of each month. Any change affecting eligibility or benefits reported during a month shall be effective the first day of the next calendar month except as follows:

a. When the recipient reports a new person to be added to the eligible group, and that person meets eligibility requirements, a payment adjustment shall be made for the month of report, subject to the effective date of grant limitations prescribed in 441—40.26(239B).

b. When cancellation of assistance occurs later because issuance of a timely notice, as required by 441—7.7(17A), requires that the action be delayed until the first day of the second calendar month, any overpayment received in the first calendar month shall be recouped.

c. When the recipient reports a change in income or circumstances timely, as defined in 40.24(1) or 40.27(4), the department shall determine prospective eligibility and the grant amount for the following month based on the change.

(1) A payment adjustment shall be made when indicated.

(2) Recoupment shall be made for any overpayment, with one exception. When a change in income is timely reported by a recipient and timely acted upon by the department, but the timely notice, as required by 441—7.7(17A), requires the action be delayed until the second calendar month following the month of change, and eligibility continues, recoupment shall not be made.

d. When an individual included in the eligible group becomes ineligible, that individual's needs shall be removed prospectively effective the first day of the next calendar month. When the action must be delayed due to administrative requirements, a payment adjustment or recoupment shall be made when appropriate.

e. When a sanction under 441—paragraph 41.22(6)*"f"* is implemented, the change shall be effective:

(1) The first day of the next calendar month after the change has occurred when the income maintenance unit determines noncooperation; or

(2) After the income maintenance unit receives notification from the child support recovery unit when the child support recovery unit determines noncooperation.

f. When a sanction under 441—paragraph 41.22(6)*"f"* is removed, the change shall be effective the first day of the next calendar month after the recipient has expressed willingness to cooperate, as described in 441—paragraph 41.22(6)*"f."* However, action to remove the sanction shall be delayed until:

(1) Cooperation has actually occurred; or

(2) The income maintenance unit has received notification from the child support recovery unit that the client has cooperated.

g. A different effective date shall be applied when specifically indicated in family investment program rules, such as in 441—subrule 41.25(5) and 441—subparagraph 41.27(9)*"c"*(2).

This rule is intended to implement Iowa Code sections 239B.2, 239B.3, 239B.5, 239B.6 and 239B.18.

[**ARC 7740B**, IAB 5/6/09, effective 6/10/09; **ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 0148C**, IAB 6/13/12, effective 8/1/12; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—40.28(239B) Referral for investigation. The department may refer questionable cases to the department of inspections and appeals for further investigation. Referrals shall be made using Form 470-2998, Referral for Front End Investigation.

This rule is intended to implement Iowa Code section 239B.5.

441—40.29(239B) Conversion to the X-PERT system. Rescinded IAB 10/4/00, effective 12/1/00.

These rules are intended to implement Iowa Code chapter 239B.

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CHAPTER 41
GRANTING ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—41.1 to **41.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

441—41.21(239B) Eligibility factors specific to child.

41.21(1) *Age.* The family investment program shall be available to a needy child under the age of 18 years without regard to school attendance.

A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The family investment program shall also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2)*"e,"* and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Rescinded, effective June 1, 1988.

41.21(3) *Residing with relative.* The child shall be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

41.21(4) Rescinded, effective July 1, 1980.

41.21(5) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code sections 239B.1, 239B.2 and 239B.5.

441—41.22(239B) Eligibility factors specific to payee.

41.22(1) Reserved.

41.22(2) Rescinded, effective June 1, 1988.

41.22(3) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father—adoptive father.

Mother—adoptive mother.

Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

Second cousins, meaning the son or daughter of one's parent's first cousin.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The family investment program is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the income maintenance unit shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family investment program family or other sources of information indicate that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the income maintenance unit shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support recovery unit.* The income maintenance unit shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

a. A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. "Prompt notice" means within two working days of the date assistance is approved.

41.22(6) *Cooperation in obtaining support.* Each applicant for or recipient of the family investment program shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

(4) Rescinded IAB 12/3/97, effective 2/1/98.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the office of the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the income maintenance unit in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. In the circumstance as described at paragraph *"b,"* subparagraph (4), the income maintenance unit shall make the determination of whether or not the applicant or recipient has cooperated. In all other instances, the child support recovery unit shall make the determination of whether the applicant or recipient has cooperated. The child support recovery unit delegates the income maintenance unit to make this determination for applicants.

f. Failure to cooperate shall result in a sanction to the family. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction shall be implemented after the noncooperation has occurred. The sanction shall remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction shall be delayed until cooperation has occurred.

(2) When the child support recovery unit (CSRU) makes the determination, the sanction shall be implemented upon notification from CSRU to the income maintenance unit that the client has failed to cooperate. The sanction shall remain in effect until the client has expressed to either income maintenance or CSRU staff willingness to cooperate. However, any action to remove the sanction shall be delayed until income maintenance is notified by CSRU that the client has cooperated.

41.22(7) *Assignment of support payments.* Each applicant for or recipient of assistance shall assign to the department any rights to support from any other person that the applicant or recipient may have. The assignment of support payments shall include rights to support in the applicant's or recipient's own behalf or in behalf of any other family member for whom the applicant or recipient is applying or receiving assistance.

a. The assignment of support payments shall include rights to all support payments that accrue during the period of assistance but shall not exceed the total amount of assistance received.

b. An assignment is effective the same date all eligibility information is entered into the department's computer system and is effective for the entire period for which assistance is paid.

41.22(8) *Good cause for refusal to cooperate.* Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought; or

(2) Emotional harm to the child for whom support is to be sought; or

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that

because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.22(9) *Claiming good cause.* Each applicant for or recipient of the family investment program who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the income maintenance unit shall notify the applicant or recipient using Form 470-0169, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the family investment program.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or recipient shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the income maintenance unit to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the department's investigation when necessary, the income maintenance unit will determine whether cooperation would be against the best interest of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.22(10) *Determination of good cause.* The income maintenance unit shall determine whether good cause exists for each applicant for or recipient of the family investment program who claims to have good cause.

a. The applicant or recipient shall be notified by the income maintenance unit of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in 41.22(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after the unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records which indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing corroborative evidence, the income maintenance unit shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit will investigate the good cause claim when the unit believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and investigation which is conducted satisfies the income maintenance unit that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve the participation of the child or caretaker.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination, and the income maintenance unit shall consider any recommendation from the child support recovery unit.

b. The determination shall:

(1) Be in writing,

(2) Contain the income maintenance unit's findings and basis for determination, and

(3) Be entered into the family investment program case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement shall not apply to a payee who is not a member of the eligible group.

a. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described at 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) *Department of workforce development registration and referral.* Rescinded IAB 11/1/00, effective 1/1/01.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive family investment program benefits unless good cause for not living with the parent or legal guardian is established.

a. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment which is located in the home of the adult parent or legal guardian.

b. For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described at 441—subrule 40.24(2).

(1) If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child shall be approved as early as seven days from receipt of the application provided they are otherwise eligible.

(2) If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child shall be denied.

c. For recipients, when changes occur, continuing eligibility shall be redetermined according to 441—subrules 40.27(4) and 40.27(5).

d. A minor parent determined to have good cause for not living with a parent or legal guardian must attend FaDSS or other family development as required in 441—subrule 93.4(4).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause shall exist when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.

b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following shall be considered:

1. The present emotional state of the individual subject to emotional harm.
2. The emotional health history of the individual subject to emotional harm.
3. Intensity and probable duration of the emotional impairment.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department of human services.

g. Other circumstances exist which indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations which appear to meet this good cause reason must be referred to the administrator of the division of economic assistance, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian shall have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The department shall determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient shall be notified by the department of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the department's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. When the department determines that good cause does not exist:

(1) The applicant or recipient shall be so notified.

(2) The application shall be denied or family investment program assistance canceled.

(3) Rescinded IAB 8/31/05, effective 11/1/05.

c. The department shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described at 441—subrule 40.24(1) and paragraph 40.27(4)*"c."*

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records which verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the department wishes to request additional corroborative evidence which is needed to permit a good cause determination, the department shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the department shall:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

This rule is intended to implement Iowa Code chapter 239B.

[**ARC 8004B**, IAB 7/29/09, effective 10/1/09]

441—41.23(239B) Home, residence, citizenship, and alienage.

41.23(1) *Iowa residence.*

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.23(3) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the assistance unit, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps,

Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as defined for children in 41.24(2)*"e"* and for adults in rule 441—93.8(239B), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code section 239B.2 and who meets either of the following requirements shall be eligible for participation in the family investment program:

a. The person is a conditional resident alien who was battered or subjected to extreme cruelty, or whose child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, as described in 8 CFR Section 216.5(a)(3).

b. The person was battered or subjected to extreme cruelty, or the person's child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, and the person's petition has been approved or a petition is pending that sets forth a prima facie case that the person has noncitizen status under any of the following categories:

(1) Status as a spouse or child of a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(1)(A).

(2) Status as a spouse or child who was battered or subjected to extreme cruelty by a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(iii), as codified in 8 United States Code Section 1154(a)(1)(A)(iii).

(3) Classification as a person lawfully admitted for permanent residence under the federal Immigration and Nationality Act.

(4) Suspension of deportation and adjustment of status under the federal Immigration and Nationality Act, Section 244(a), as in effect before the date of enactment of the federal Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

(5) Cancellation of removal or adjustment of status under the federal Immigration and Nationality Act, Section 240A, as codified in 8 United States Code Section 1229b.

(6) Status as an asylee, if asylum is pending, under the federal Immigration and Nationality Act, Section 208, as codified in 8 United States Code Section 1158.

41.23(5) *Citizenship and alienage.*

a. *Eligible status.* A family investment program assistance grant may include the needs of a citizen or national of the United States or a qualified alien as defined at rule 441—40.21(239B).

(1) A person who is a qualified alien as defined at rule 441—40.21(239B) is not eligible for family investment program assistance for a five-year period beginning on the date of the person's entry into the United States with a qualified alien status.

(2) EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to:

1. A qualified alien residing in the United States before August 22, 1996.
2. A battered alien as described at subrule 41.23(4).
3. A qualified alien veteran who has an honorable discharge that is not due to alienage.
4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph "3" or "4," including a surviving spouse who has not remarried.

6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA).

7. An alien granted asylum under Section 208 of the INA.

8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V).

9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).

10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.

11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. *Attestation of status.* As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on Form 470-0462 or 470-0462(S), Financial Support Application, or Form 470-2549, Statement of Citizenship Status. Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

(1) The applicant;

(2) Someone acting responsibly on the applicant's or recipient's behalf if the applicant or recipient is incompetent or incapacitated; or

(3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

This rule is intended to implement Iowa Code sections 239B.2 and 239B.2B.

[**ARC 9439B**, IAB 4/6/11, effective 6/1/11; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. All persons in a family investment program (FIP) household shall be referred to the PROMISE JOBS program and shall enter into a family investment agreement (FIA) as a condition of receiving FIP, unless exempt from referral, except as described at subrule 41.24(2).

41.24(1) *FIA-responsible persons.* The following persons are FIA-responsible unless the department determines the person is exempt:

a. All persons whose needs are included in a grant under the FIP program.

b. Any parent living in the home of a child receiving a grant.

c. All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.

d. Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active limited benefit plan shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8)*"d"* and *"e"* for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

(1) The applicant has become exempt from PROMISE JOBS.

(2) The applicant is in a subsequent limited benefit plan and it is prior to the last day of the six-month period of ineligibility.

41.24(2) *Exemptions.* The following persons are exempt from referral:

a. and *b.* Rescinded IAB 12/3/97, effective 2/1/98.

c. A person who is under the age of 16 and is not a parent.

d. A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.

e. A person who is aged 16 to 19, is not a parent, and attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not

attending school, once the person has signed a family investment agreement, the person shall remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in an elementary school, a secondary school, or the equivalent level of vocational or technical school or training leading to a certificate or diploma, and the school certifies the person's attendance as full-time. Enrollment in a correspondence school that gives instruction courses by mail is not an allowable program of study.

(2) A person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, an illness, a convalescence, or a family emergency.

(3) A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

f. A person who is not a United States citizen and is not a qualified alien as defined in rule 441—40.21(239B).

41.24(3) *Parents aged 19 and under.*

a. Unless exempt as described at subrule 41.24(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) shall be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described at subrule 41.24(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent shall be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.24(4) *Method of referral.* The department shall refer each FIA-responsible person as defined at subrule 41.24(1) to PROMISE JOBS to sign a family investment agreement.

a. *FIA-responsible applicants.* During the application interview, the department shall notify the applicant of the requirement to sign a family investment agreement as a condition of FIP eligibility. The department shall refer the applicant by scheduling the applicant for an appointment with the PROMISE JOBS provider agency to develop the family investment agreement.

(1) The appointment shall be on the earliest available date but no later than ten calendar days from the date of referral unless the applicant requests an appointment on a day that is beyond ten calendar days. The PROMISE JOBS provider agency shall make sufficient appointment times available to allow the applicant to be scheduled within this time frame.

(2) The applicant shall be notified verbally and in writing of the scheduled appointment. If the notice of a scheduled appointment is mailed to the applicant, the department shall allow at least five working days from the date the notice is mailed for the applicant to appear for the scheduled appointment. The department may allow less than five working days if the applicant is verbally notified and agrees to the appointment.

(3) If a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the entire family.

(4) If a minor parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the minor parent and any child of the minor parent.

(5) If a referred person who is not a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance only for that person.

b. Hardship applicants. While the eligibility decision is pending, the department shall refer applicants who must qualify for a hardship exemption before approval of FIP to PROMISE JOBS to sign a family investment agreement as described in paragraph 41.24(4)*"a"* and shall treat applicants in accordance with subrule 41.30(3).

c. Applicants in a limited benefit plan. The department shall refer FIA-responsible applicants to PROMISE JOBS as described in paragraph 41.24(4)*"a"* and inform the applicant of the actions needed to reconsider and end the limited benefit plan as described at subrule 41.24(8). Failure to appear for the appointment without rescheduling or failure to sign a family investment agreement results in denial of the FIP application.

d. FIP participants who become FIA-responsible. When a person receiving FIP is no longer exempt, the department shall send the FIP participant a notice. The notice shall contain information about the requirement to sign a family investment agreement and shall instruct the FIP participant to contact PROMISE JOBS within ten calendar days to schedule an appointment with PROMISE JOBS to develop a family investment agreement. If the participant fails to schedule or attend the appointment or fails to sign a family investment agreement, PROMISE JOBS will send a clear written reminder. After one written reminder as described at 441—paragraph 93.3(3)*"b,"* the participant shall enter into a limited benefit plan as described at paragraph 41.24(8)*"c."*

41.24(5) *Changes in status and redetermination of exempt status.* Any exempt person shall report any change affecting the exempt status to the department within ten days of the change. The department shall reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The participant and the PROMISE JOBS unit shall be notified of any change in a participant's exempt status.

41.24(6) *Volunteers.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(7) *Referral to vocational rehabilitation.* The department shall make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) *The limited benefit plan (LBP).* When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.4(239B) chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant shall enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined at 441—subrule 7.7(1). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described at paragraphs 41.24(8)*"d"* and *"e."*

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of a first limited benefit plan, the FIP eligible group or individual participant shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)*"d."* If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies to the FIP eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)*"e."* A limited benefit plan imposed in error as described in paragraph 41.24(8)*"g"* shall not be considered a limited benefit plan and shall not count when determining whether a household is subject to a subsequent limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant's family as follows:

(1) When the participant responsible for the family investment agreement is a parent, the limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1).

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child's stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. EXCEPTION: The limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing a family investment agreement, each parent or needy specified relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

2. When the minor parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent's or needy specified relative's home and the minor parent chooses the limited benefit plan, the adult parent's or needy specified relative's FIP eligibility ceases in accordance with subrule 41.28(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent's limited benefit plan.

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described at subparagraph 41.24(8)*"b"*(2).

(4) When the FIP eligible group includes children who are FIA-responsible, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy specified relative responsible for a family investment agreement meets those responsibilities but a child who is FIA-responsible chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph 41.24(8)*"b"*(4)"1" is the only child in the eligible group, the parents' or needy specified relative's eligibility ceases in accordance with subrule 41.28(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are FIA-responsible, the children are responsible for completing a family investment agreement. If a child who is FIA-responsible chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph 41.24(8)*"b"*(4).

(6) When both parents of a FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan,

the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who loses exempt status and is referred to PROMISE JOBS as described at paragraph 41.24(4)*"d"* and who does not schedule or attend an appointment for orientation and development of a family investment agreement with PROMISE JOBS after PROMISE JOBS sends one clear written reminder as described at 441—paragraph 93.3(3)*"b"* shall enter into the limited benefit plan.

(2) A participant who chooses not to sign the family investment agreement shall enter into the limited benefit plan. For an applicant, signing a family investment agreement is a FIP eligibility requirement. If an applicant chooses not to sign the agreement, the limited benefit plan process is not applicable.

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall enter into a limited benefit plan whether the person signed the agreement as a FIP applicant or as a FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker's request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. Reconsideration of a first limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

(1) Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

(2) FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

e. Reconsideration of a subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

(1) A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

(2) FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

(3) To reconsider and end the limited benefit plan, the person must:

1. Contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities,

2. Sign a new or updated family investment agreement, and

3. Satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5)apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5)apply.

(4) FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

f. Reconsideration by two-parent family. For a two-parent family when both parents are responsible for a family investment agreement as described at subrule 41.24(1), a first or subsequent limited benefit plan continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in paragraphs *"d"* and *"e"* above.

g. Limited benefit plan imposed in error. A limited benefit plan imposed in error shall not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as described in the administrative rules. Examples of instances when an error has occurred are:

(1) The person was exempt from PROMISE JOBS participation at the time the person chose the limited benefit plan.

(2) It is verified that the person considered to have chosen the limited benefit plan moved out of state or requested cancellation of FIP prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

(3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

(4) It is determined that the entire amount of assistance issued for the person who chose the limited benefit plan is subject to recoupment for the month when the person chose not to fulfill the terms of the family investment agreement.

(5) The person informs PROMISE JOBS of a newly revealed problem as described at rule 441—93.14(239B) or barrier as described at 441—subrule 93.4(5) after the limited benefit plan is imposed, and it is reasonable that the problem or barrier contributed to a failure that resulted in imposition of the limited benefit plan. The person may be required to provide documentation of the problem or barrier as described at 441—subrule 93.10(3).

41.24(9) *Nonparticipation by volunteer participants.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(10) *Notification of services.*

a. The department shall inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department shall provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department shall provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information shall include explanations of child care assistance and transitional Medicaid.

d. The department shall inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department shall explain the LBP and the process by which FIA-responsible persons can choose the LBP.

f. The department shall inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department shall inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described at subrule 41.24(2).
[**ARC 9439B**, IAB 4/6/11, effective 6/1/11; **ARC 1146C**, IAB 10/30/13, effective 1/1/14; **ARC 1208C**, IAB 12/11/13, effective 2/1/14]

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in a family investment program grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care or state-funded foster care.

a. A recipient shall not concurrently receive the family investment program and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family.

b. When a family investment program recipient is approved for foster care or subsidized adoption assistance while remaining in the same home, family investment program assistance shall be canceled effective the first day of the next calendar month following the date approval of the foster care or subsidized adoption payment is successfully entered into the department's computer system. FIP assistance for the month for which the foster care or subsidized adoption payment is approved or any past months for which foster care or subsidized adoption payments are made retroactively shall not be subject to recoupment.

c. A recipient shall not concurrently receive a grant from a public assistance program in another state.

d. When a recipient leaves the home of a specified relative, no payment for a concurrent period shall be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization shall be limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance shall be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the family investment program when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living shall be ineligible for the family investment program for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual shall be ineligible for the family investment program for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The district administrator shall determine whether such a risk to the individual's physical or emotional well-being exists.

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) *Time limit for receiving assistance.* Rescinded IAB 7/11/01, effective 9/1/01.

41.25(8) *School attendance requirements.* Rescinded IAB 7/7/04, effective 7/1/04.

41.25(9) *Pilot diversion programs.* Assistance shall not be approved when an assistance unit is subject to a period of ineligibility as described at 441—Chapter 47.

41.25(10) *Fugitive felons, and probation and parole violators.* Assistance shall be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

41.25(11) *Access to benefits.*

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined by federal statute or regulation applicable to this prohibition:

(1) A liquor store,

(2) A casino, gambling casino or gaming establishment, or

(3) A retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

b. When the department receives a detailed complaint or suspects that a recipient has used the recipient's electronic access card at a prohibited location, the case shall be referred to the department of inspections and appeals for further investigation.

c. When the department of inspections and appeals finds that a recipient has used the recipient's electronic access card at a prohibited location, the household that includes the recipient is:

(1) Considered to have committed a fraudulent act;

(2) Liable for any amounts accessed at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;

(3) Ineligible for FIP for a three-month period after the first report by the department of inspections and appeals which includes a finding of misuse;

(4) Ineligible for FIP for a six-month period after each subsequent report by the department of inspections and appeals which includes a finding of misuse.

d. When parents from a two-parent family separate during an ineligibility period, if:

(1) The department of inspections and appeals investigation identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.

(2) The department of inspections and appeals investigation does not identify the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow the recipient who is the case name when the violation occurred.

e. A new period of ineligibility shall be established when:

(1) A recipient timely appeals the notice of decision establishing the ineligibility period,

(2) Assistance is continued pending the final decision of the appeal, and

(3) The department's action is affirmed.

Assistance issued pending the final decision of an appeal is not subject to recovery pursuant to 441—subrule 7.9(6).

This rule is intended to implement Iowa Code chapter 239B.

[**ARC 1207C**, IAB 12/11/13, effective 2/1/14; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—41.26(239B) Resources.

41.26(1) *Limitation.* An applicant or recipient may have the following resources and be eligible for the family investment program. Any resource not specifically exempted shall be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 41.26(1)*"n"* or *"o"* and 41.26(6)*"d,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of $4115 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of $4115 of any vehicle shall be counted toward the resource limit in 41.26(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

The department shall annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2000 for applicant assistance units and $5000 for recipient assistance units. EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the $5000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described at rules 441—45.26(239B) and 45.27(239B) and persons whose grants were suspended as in 41.27(9)*"f"* in the month prior to the month of application.

Resources of the applicant or the recipient shall be determined in accordance with subrule 41.26(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined in 41.27(9)*"c"*(2)reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 41.27(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in computing whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

41.26(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group shall be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income recipients shall not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

f. and *g.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½-acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 41.26(5).

41.26(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.27(1)*"f"* and 41.27(7)*"ah."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.26(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.26(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.26(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

41.26(8) *Trusts.* The department shall determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

b. When the department questions whether the funds in a trust or conservatorship are available, the trust or conservatorship shall be referred to the central office.

(1) When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(2) Funds in a trust or conservatorship that are not clearly available shall be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the resources of the alien shall be deemed to include the resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the resources of the sponsor and the sponsor's spouse deemed to the alien shall be the total countable resources as described in rule 441—41.26(239B) remaining after a $1,500 deduction is subtracted. The following are exceptions to deeming of a sponsor's resources:

a. Deeming of the sponsor's resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's resources for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's resources for 12 months.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, and inventory or supplies retained by the household shall not be considered a resource.

This rule is intended to implement Iowa Code section 239B.5.

[**ARC 9439B**, IAB 4/6/11, effective 6/1/11]

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant.

1. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family

investment program grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group.

3. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)*"h"*(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)*"q."* Deductions and diversions shall be allowed when verification is provided.

41.27(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

d. Rescinded IAB 2/11/98, effective 2/1/98.

e. Rescinded IAB 2/11/98, effective 2/1/98.

f. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

g. Every person in the eligible group and any parent living in the home of a child in the eligible group shall take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph (2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2)*"c."*

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described at 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

h. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, shall be treated as unearned income and deducted from the initial assistance

grant(s). Any cash support payment for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by the recipient after the date of decision as defined in 441—subrule 40.24(4) shall be refunded to the child support recovery unit.

(2) Assigned support collected in a month and retained by child support recovery shall be exempt as income for determining prospective or retrospective eligibility. Participants shall have the option of withdrawing from FIP at any time and receiving their child support direct.

(3) and (4) Rescinded IAB 12/3/97, effective 2/1/98.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined at rule 441—40.21(239B). When the information is available, the department shall verify job insurance benefits by using information supplied to the department by the department of workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A payment adjustment shall be made when indicated. Recoupment shall be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision, Form 470-0485(C) or 470-0486(M), applicable to the payment month, whichever is later, in order to receive a payment adjustment.

41.27(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Earned income deduction. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses shall include, but not be limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Rescinded IAB 12/29/99, effective 3/1/00.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined in paragraph 41.27(2)*"a"* and income diversions as defined in subrules 41.27(4) and 41.27(8), the department shall disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described at subparagraphs 41.27(9)*"a"*(2) and (3).

d. Self-employment. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

e. Self-employment income. Earned income from self-employment as defined in paragraph 41.27(2)*"d"* means the net profit from self-employment. "Net profit" means gross self-employment income less:

(1) Forty percent of the gross income to cover the costs of producing the income, or

(2) At the request of the applicant or recipient, actual expenses determined in the manner specified in paragraph 41.27(2)*"f."*

f. *Deduction of self-employment expenses.* When the applicant or recipient requests that actual expenses be deducted, the net profit from self-employment income shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent; the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. *Child care income.* Gross income from providing child care in the applicant's or recipient's own home shall include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

h. *Income verification.* The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—40.21(239B). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) *Shared living arrangements.* When a family investment program parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the family investment program eligible group, exclusively for their needs, are considered income.

41.27(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within family investment program standards. The maximum income that shall be diverted to meet the needs of the ineligible child(ren) shall be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in 41.27(8)*"a"*(2) and 41.27(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents shall be treated in accordance with subparagraphs (1), (2), and (4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) shall be treated in accordance with 41.27(8)*"c."*

(3) Rescinded IAB 4/3/91, effective 3/14/91.

(4) When the unmarried specified relative is age 18, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority.

41.27(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 41.22(3), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Rescinded IAB 2/11/98, effective 2/1/98.

t. Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

u. The first $50 received and retained by an applicant or recipient which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility and benefit amount. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in 41.27(2)*"a"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

ac. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1)*"h"*(2).

41.27(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for job-related expenses.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family providing foster care to a child or children when the family is operating a licensed foster home.

e. Rescinded IAB 5/1/91, effective 7/1/91.

f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

g. Federal or state earned income tax credit.

h. Supplementation from county funds providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the family investment program, or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

j. A retroactive corrective payment.

k. The training allowance issued by the division of vocational rehabilitation, department of education.

l. Payments from the PROMISE JOBS program.

m. Rescinded, effective July 1, 1989.

n. The training allowance issued by the department for the blind.

o. Payment(s) from a passenger(s) in a car pool.

p. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

q. Rescinded IAB 11/8/06, effective 1/1/07.

r. Rescinded IAB 11/8/06, effective 1/1/07.

s. Income of a nonparental relative as defined in 41.22(3) except when the relative is included in the eligible group.

t. Rescinded IAB 11/8/06, effective 1/1/07.

u. Rescinded IAB 9/11/96, effective 11/1/96.

v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

x. Rescinded, effective July 1, 1986.

y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in 41.24(2)*"e."* The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with 41.27(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Rescinded IAB 12/3/97, effective 2/1/98.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. Rescinded IAB 12/3/97, effective 2/1/98.

ag. Rescinded IAB 11/8/06, effective 1/1/07.

ah. Welfare reform and regular household honorarium income. All moneys paid to a FIP household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ai. Diversion or self-sufficiency grants assistance as described at 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4)*"b"* and 41.27(1)*"f."*

ak. All census earnings received by temporary workers from the Bureau of the Census.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described at paragraph 41.27(2)*"a,"* the work incentive disregard described at paragraph 41.27(2)*"c,"* and diversions described at subrule 41.27(4).

(2) The excluded parent shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at subrule 41.27(11).

(3) All remaining income of the excluded parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) to (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in 41.27(8)*"b"*(1) to (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the family investment program standard of need for a family group of the same composition.

(6) The stepparent shall be allowed the work incentive disregard described at paragraph 41.27(2)*"c"* from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions in subparagraphs 41.27(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 41.27(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described at 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. *Treatment of income in underage parent cases.* In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parent(s), the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with 41.27(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with 41.27(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit; the self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

41.27(9) *Budgeting process.* Both initial and ongoing eligibility and benefits shall be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made shall be considered to determine eligibility for the family investment program, except income which is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview shall be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with 41.27(9)*"c"*(1) and 41.27(9)*"i,"* the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision shall be deducted from earned income, except when determining eligibility under the 185 percent test defined in rule 441—41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application shall be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in rule 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need shall then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2)*"c."* All other appropriate exemptions, deductions and diversions are applied.

Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application shall be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application shall be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the family investment program grant shall be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9)*"a"*(4).

(4) Eligibility for the family investment program for any month or partial month before the month of decision shall be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision shall be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month shall be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described at subrule 41.30(1), family investment program eligibility shall be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

(6) Rescinded IAB 11/8/06, effective 1/1/07.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

b. Ongoing eligibility.

(1) The department shall prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.27(3). All countable earned and unearned income received by the eligible group during the previous 30 days shall be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department shall prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Rescinded IAB 11/8/06, effective 1/1/07.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2)*"a"* and the work incentive disregard as defined in paragraph 41.27(2)*"c"* shall be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be considered as income in the month received. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be considered as income in the month received, except periodic or intermittent income from self-employment shall be treated as described in 41.27(9)*"i."* When the income that is subject to proration is earned, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4), 41.26(7), 41.27(8)*"b,"* and 41.27(8)*"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income shall be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for

example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the family investment program grant but including countable lump-sum income, exceeds the needs of the eligible group, the case shall be canceled or the application rejected. In addition, the eligible group shall be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation shall be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility shall begin with the month the lump sum is received.

When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4)*"f,"* recoupment shall not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—7.7(17A) requires the action be delayed until the second calendar month following the month of change, recoupment shall not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment shall be made beginning with the month of receipt.

The period of ineligibility shall be shortened when the schedule of living costs as defined in 41.28(2) increases.

The period of ineligibility shall be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

The period of ineligibility shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum shall be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the family investment program as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment shall be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6)*"f."*

e. In any month for which an individual is determined eligible to be added to a currently active family investment program case, the individual's needs shall be included subject to the effective date of grant limitations as prescribed in 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual shall be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month.

f. Rescinded IAB 11/8/06, effective 1/1/07.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result shall be multiplied by

four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3), (4), and (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in 41.28(3) must be documented before payment shall be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment shall be included, prospectively, in each month's family investment program grant. When the special need ends, payment shall be removed prospectively. Any overpayment for a special need shall be recouped.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the family investment program as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person shall be considered prospectively in accordance with 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income of the alien shall be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien shall be the total gross earned and unearned income remaining after allowing the earned income deduction described at paragraph 41.27(2)*"a,"* the work incentive disregard described at paragraph 41.27(2)*"c,"* and diversions described at subrule 41.27(4). The following are exceptions to deeming of a sponsor's income:

a. Deeming of the sponsor's income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's income for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income for 12 months.

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.29(239B), or who is required to be included in the eligible group according to 41.28(1)*"a"* and has failed to cooperate. This restriction applies to 41.27(4)*"a"* and 41.27(8).

This rule is intended to implement Iowa Code section 239B.7.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 9043B**, IAB 9/8/10, effective 11/1/10; **ARC 9439B**, IAB 4/6/11, effective 6/1/11; **ARC 0148C**, IAB 6/13/12, effective 8/1/12; **ARC 1478C**, IAB 6/11/14, effective 8/1/14]

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There shall be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons shall be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

(4) Rescinded IAB 6/30/99, effective 7/1/99.

41.28(2) *Schedule of needs.* The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the standard of need defined in 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with 441—41.27(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for a family investment program grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the payment standard defined in 441—40.21(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving the family investment program assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the family investment program, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the family investment program but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the family investment program, the needs of the specified relative, when eligible, shall be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in 41.22(3), only the needs of the eligible children shall be included in the assistance grant. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources shall not be considered in determining family investment program benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant shall be computed on the basis of their comprising one eligible group. This rule shall not be construed to require that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs shall be allowed, in addition to the basic needs.

a. *School expenses.* Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, shall be allowed provided the allowance shall not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. *Guardian/conservator fee.* An amount not to exceed $10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

c. *FIP special needs classroom training.* Rescinded IAB 12/3/97, effective 2/1/98.

d. *Job Training Partnership Act.* Rescinded IAB 12/3/97, effective 2/1/98.

41.28(4) *Period of adjustment.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code section 239B.5.

441—41.29(239B) Composite FIP/SSI cases. When persons in the family investment program household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following rules shall apply.

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the family investment program grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the family investment program recipient, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

This rule is intended to implement Iowa Code section 239B.5.

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or any state program in Iowa or in another state that is funded by the Temporary Assistance for Needy Families (TANF) block grant. The 60-month period need not be consecutive.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraphs 41.28(1)*"b"*(1), (2) and (3). In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

b. "Assistance" shall include any month for which the adult receives a FIP grant. Assistance received for a partial month shall count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department shall consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are supplemental security income (SSI) recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1)*"b"*(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described at subparagraph 41.28(1)*"b"*(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent's case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department shall not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

(3) Rescinded IAB 1/9/02, effective 3/1/02.

(4) Rescinded IAB 1/9/02, effective 3/1/02.

e. The department shall not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a

household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent's or the specified relative's FIP case.

f. The department shall not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. "Hardship" is defined as a circumstance that is preventing the family from being self-supporting. However, the family's safety shall take precedence over the goal of self-sufficiency.

a. Exclusions. Families with an adult as defined in subrule 41.30(1) who is not a U.S. citizen or a qualified alien as defined in rule 441—40.21(239B) are prohibited from receiving more than 60 months of FIP assistance. The family of an adult who is a nonqualified alien cannot meet the requirements of paragraph *"g"* of this subrule since the department is precluded from using public funds to provide a nonqualified alien with family investment agreement or PROMISE JOBS services by Iowa Code sections 239B.8 and 239B.18 and rule 441—41.24(239B).

b. Eligibility determination. Eligibility for the hardship exemption shall be determined on an individual family basis. A hardship exemption shall not begin until the adult in the family has received at least 60 months of FIP assistance.

c. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include, but are not limited to, the following:

(1) Domestic violence. "Domestic violence" means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.
5. Threats of, or attempts at, physical or sexual abuse.
6. Mental abuse.
7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.4(5).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient shall follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance abuse issues. A family requesting a hardship exemption due to substance abuse shall be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include, but is not limited to, a child as defined in rule 441—170.1(234) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child shall take precedence over the goal of self-sufficiency.

(8) Rescinded IAB 1/8/03, effective 1/1/03.

(9) Other circumstances which prevent the family from being self-supporting.

d. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that were known and existing before the family reached the 60-month limit shall not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

e. Requesting a hardship exemption.

(1) Families with adults as defined in subrule 41.30(1) who have or are close to having received 60 months of FIP assistance may request a hardship exemption. Requests for the hardship exemption shall be made on Form 470-3826, Request for FIP Beyond 60 Months. In addition, families that have received FIP for 60 months shall complete Form 470-0462 or Form 470-0462(S), Financial Support Application, as described at rule 441—40.22(239B) as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request shall result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption shall not be accepted prior to the first day of the family's fifty-ninth month of FIP assistance. The date of the request shall be the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received FIP for 60 months joins a recipient family that has not received 60 months of FIP assistance, eligibility shall continue only if the recipient family submits Form 470-3826 and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period shall continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, shall follow the parent who retains the current FIP case.

f. Determination of hardship exemption.

(1) A determination on the request shall be made as soon as possible, but no later than 30 days following the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. A written notice of decision shall be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption.

The 30-day time standard shall apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) shall apply.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the department shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)*"c."* Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new Form 470-3826. A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

g. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.24(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

(2) Families that request a hardship exemption shall be notified verbally and shall be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both

parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.4(8).

(6) Any family that has been granted a hardship exemption and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

h. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

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CHAPTER 42
UNEMPLOYED PARENT

[Prior to 7/1/83, Social Services[770] Ch 42]
[Prior to 2/11/87, Human Services[498]]

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

CHAPTER 43
ALTERNATE PAYEES

[Prior to 7/1/83, Social Services[770] Ch 43]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—43.1 to **43.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—43.1(239) to 43.4(239)]

441—43.21(239B) Conservatorship or guardianship.

43.21(1) When application is filed for the family investment program by a person under conservatorship or guardianship, a copy of the court order shall be secured by the department. Assistance payments shall be made to the conservator or guardian to be allocated for the support and care of the dependent child.

43.21(2) Rescinded IAB 8/31/05, effective 11/1/05.

441—43.22(239B) Protective payments. Rescinded IAB 8/31/05, effective 11/1/05.

441—43.23(239B) Vendor payments. Rescinded IAB 8/31/05, effective 11/1/05.

441—43.24(239B) Emergency payee. Payments may be made to persons acting for relatives who have been receiving assistance for a child in emergency situations that deprive the child of the relatives' care. These payments shall be made for a temporary period, not to exceed three months, to allow time to make and implement plans for the child's continuing care and support.

These rules are intended to implement Iowa Code section 239B.13.

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CHAPTER 44
Rescinded, effective 10/1/85

CHAPTER 45
PAYMENT

[Ch 45, January 1974 IDR Supplement, renumbered as [770] Ch 42]
[Prior to 7/1/83, Social Services[770] Ch 45]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—45.1 to **45.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—45.1(239) to 45.7(239)]

441—45.21(239B) Issuing payment. The department may issue assistance payments under the family investment program (FIP):

1. By electronic access card,
2. By direct deposit to the recipient's own account in a financial institution, or
3. By warrant.

45.21(1) *Electronic access card.* The department shall make payments available through an electronic access card issued to the payee except when:

a. The recipient requests direct deposit; or

b. The department determines it is not practicable to issue the payment by electronic access card.

45.21(2) *Direct deposit.* The department shall issue payments by direct deposit to the recipient's own account in a financial institution if the recipient completes Form 470-0261, Agreement for Automatic Deposit, to request direct deposit.

45.21(3) *Warrant.* The department shall issue payments by warrant when the recipient has not requested direct deposit and the department determines it is not practicable to issue payment by electronic access card. These circumstances include but are not limited to the following:

a. A one-time payment is issued.

b. The payee is a representative payee, conservator, or guardian who is not part of the FIP assistance unit.

c. The payee is unable to provide a social security number or an individual taxpayer identification number.

[**ARC 8005B**, IAB 7/29/09, effective 10/1/09; **ARC 8204B**, IAB 10/7/09, effective 11/11/09]

441—45.22(239B) Return. Assistance warrants are not forwardable. When warrants cannot be delivered by the post office, they shall be returned to the department.

441—45.23(239B) Held warrants. A warrant may be held by the department only in the following instances:

45.23(1) The recipient's whereabouts is unknown.

45.23(2) The recipient is not in the home due to an emergency and it is not known who will be serving as emergency payee.

441—45.24(239B) Underpayment. A corrective payment shall be made when the recipient receives a payment in an amount less than that for which the recipient was eligible due to an administrative or client error or the recipient reports the completion of the federal tax return requiring repayment to Internal Revenue Service of excess advance earned income credit payments received in the prior calendar year.

45.24(1) Attribution of underpayments.

a. An underpayment may be attributed to the department as a result of one 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 certify assistance in the correct amount when all essential information was available to the department.

(6) Failure to make prompt revisions in grants following changes in policies requiring the changes as of a specific date.

b. An underpayment may be attributed to the client as a result of one of the following circumstances:

(1) Information reported in error, oral or written, regarding the client's income, resources, or other circumstances which may affect eligibility or the amount of assistance received.

(2) Failure to timely report changes in income, resources, or other circumstances which may affect eligibility or the amount of assistance received.

(3) Rescinded IAB 12/11/02, effective 2/1/03.

45.24(2) Conditions under which a retroactive corrective payment may be made.

a. Retroactive corrective payments shall be made for all underpayments.

b. Any retroactive corrective payment for which the recipient is eligible shall first be applied to any unpaid overpayment before the balance, if any, is paid to the recipient.

c. Retroactive corrective payments shall be made for underpayments discovered on and after October 1, 1981, regardless of when the underpayment occurred. Recipients and former applicants and recipients are responsible for supplying any information needed to determine the amount of an underpayment.

45.24(3) The amount of the corrective payment to the recipient for repayment to Internal Revenue Service of excess advance earned income credit payments shall be computed on the basis of the earnings considered in determining the family investment program grant for the prior year.

45.24(4) A retroactive corrective payment is:

a. Exempt from consideration as income.

b. Exempt from consideration as a resource in the month received and the following month.

441—45.25(239B) Deceased payees. A retroactive corrective payment shall be made for deceased payees only when the payment was approved by the department before the recipient's death. Payment for a special need shall be made only when the payment is entered on the automated benefit calculation system before the effective date of cancellation.

441—45.26(239B) Limitation on payment. A payment shall be made to an eligible recipient only when the amount of the assistance is $10 or more.

441—45.27(239B) Rounding of need standard and payment amount. The need standard and monthly payment amount must be rounded down to the next whole dollar when the result of determining the standard of need or the payment amount is not a whole dollar.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, and 239B.7.

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CHAPTER 46
OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—46.1 to **46.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—46.1(239) to 46.8(239)]

441—46.21(239B) Definitions.

"Agency error" in overpayments means: (a) The same as circumstances described in 441—subrule 45.24(1) pertaining to underpayments, or (b) any error that is not a client or procedural error.

"Client" means a current or former applicant or recipient of the family investment program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which may affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances as required by rule 441—40.27(239B);
3. Failure to refund to the child support recovery unit any nonexempt payment from the absent parent received after the date the decision on eligibility was made; or
4. Access of benefits issued via the electronic access card at a prohibited location pursuant to 441—subrule 41.25(11).

"Overpayment" means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive or the amount of any payment accessed at a prohibited location pursuant to 441—subrule 41.25(11).

"Procedural error" means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

1. Failure to secure a properly signed application at the time of initial application or reapplication.
2. Failure to secure a properly signed Form 470-3826, Request for FIP Beyond 60 Months, as described at 441—subrule 41.30(3).
3. Failure of the department to conduct the interviews described in 441—subrules 40.24(2) and 40.27(1).
4. Failure to request a Review/Recertification Eligibility Document at the time of a semiannual or annual review.
5. Failure of department staff to cancel the family investment program benefits when the client submits a Review/Recertification Eligibility Document that is not complete as defined in 441—paragraph 40.27(4)*"b."* However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

"Recoup" means reimburse, return, or repay an overpayment.

"Recoupment" means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

[**ARC 1207C**, IAB 12/11/13, effective 2/1/14]

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments shall be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued shall be for no less than $10.

441—46.23(239B) Notification and appeals. All clients shall be notified by the department of inspections and appeals, as described at 441—subrule 7.5(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's request. The client 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).

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision shall be recouped. A procedural error alone does not result in an overpayment.

46.24(1) *Agency error.* When an overpayment is due to an agency error, recoupment shall be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant.

a. An overpayment of any amount is subject to recoupment with one exception: When the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment shall be made only when the amount received exceeds the amount on the notice by $10 or more.

b. An overpayment due to agency error shall be computed as if the information had been acted upon timely.

46.24(2) *Assistance paid pending appeal decision.* Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing shall begin no later than the month after the month in which the final decision is issued.

46.24(3) *Client error.*

a. An overpayment due to client error shall be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent shall be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.22(6).

c. An overpayment due to a recipient's accessing benefits via the electronic access card at a prohibited location shall be the total of the transactions at prohibited locations pursuant to 441—subrule 41.25(11).

46.24(4) *Failure to cooperate.* Failure to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months.

46.24(5) *Overpayment in special alien cases.* Rescinded IAB 10/4/00, effective 12/1/00.

46.24(6) *Real property exempted as a resource.* Rescinded IAB 6/30/99, effective 9/1/99.

[**ARC 1207C**, IAB 12/11/13, effective 2/1/14]

441—46.25(239B) Source of recoupment. Recoupment shall be made from basic needs. The minimum recoupment amount shall be the amount prescribed in 46.25(3). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections and appeals, or have repayment withheld from the grant. The client shall sign Form 470-0495, Repayment Contract, when requested to do so by the department of inspections and appeals. When the client fails to make the agreed upon payment, the agency shall reduce the grant.

46.25(1) and **46.25(2)** Rescinded, effective February 8, 1984.

46.25(3) *Basic needs.*

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under rule 441—7.9(217) or a combination

of continued benefits and agency or client errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error shall be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

d. Rescinded IAB 6/30/99, effective 9/1/99.

46.25(4) *Recoupment in special alien cases.* Rescinded IAB 10/4/00, effective 12/1/00.

441—46.26 Rescinded, effective February 8, 1984.

441—46.27(239B) Procedures for recoupment.

46.27(1) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(2) *Referral.* When the department determines that an overpayment exists, the case shall be referred to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

46.27(3) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(4) *Change of circumstances.* When financial circumstances change, the recoupment plan is subject to revision.

46.27(5) *Collection.* Recoupment for overpayments shall be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.22(3), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.27(6) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than $35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than $35 which have been held in suspense for three years.

441—46.28(239B) Intentional program violation. Rescinded IAB 11/8/06, effective 1/1/07.

441—46.29(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states shall be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, or the Food Stamp Act of 1977, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14.

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CHAPTER 47
DIVERSION INITIATIVES

DIVISION I
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

PREAMBLE

These rules implement the Iowa promoting awareness of the benefits of a healthy marriage program. This program uses federal funds from the Temporary Assistance to Needy Families (TANF) block grant to provide information to certain households about the benefits of a healthy and stable marriage. Eligibility for this program also establishes categorical eligibility for the Iowa food assistance program under 441—Chapter 65.

[**ARC 9172B**, IAB 11/3/10, effective 1/1/11; **ARC 9350B**, IAB 2/9/11, effective 4/1/11]

441—47.1(234) Eligibility criteria. Eligibility for the promoting awareness of the benefits of a healthy marriage program is always determined in conjunction with determination of eligibility for food assistance under 441—Chapter 65.

47.1(1) *Application.* There is no separate application for the program. Eligibility for the program is determined whenever the department determines a household's eligibility for food assistance.

47.1(2) *Resources.* There is no asset test for the program.

47.1(3) *Income.* The household's gross countable monthly income determined according to rule 441—65.29(234) must be less than or equal to 160 percent of the current federal poverty guidelines for the household size. The income eligibility limits as described in this subrule are revised each October 1 to reflect the annual adjustment to the federal poverty guidelines.

47.1(4) *Otherwise eligible for food assistance.* The household must meet all eligibility criteria for food assistance except as provided in this rule. A household that includes a member who is currently disqualified from food assistance due to an intentional program violation is not eligible for the program.

47.1(5) *Minimum food assistance benefit.* The household must be eligible for a monthly food assistance benefit greater than zero. Households with a monthly food assistance benefit of zero are not eligible for the program.

[**ARC 9172B**, IAB 11/3/10, effective 1/1/11; **ARC 9350B**, IAB 2/9/11, effective 4/1/11]

441—47.2(234) Notice and eligibility period. A household that meets all of the eligibility criteria in rule 441—47.1(234) shall receive written notice of its eligibility for the promoting awareness of the benefits of a healthy marriage program.

47.2(1) *Written information.* Households determined eligible for the program shall receive written information about the benefits of a healthy and stable marriage.

47.2(2) *Eligibility period.* A household that is determined eligible for the program shall remain eligible for the program until the earlier of the following events:

a. The household fails to meet the eligibility criteria under rule 441—47.1(234), or

b. The household's food assistance certification period under 441—Chapter 65 ends.

[**ARC 9172B**, IAB 11/3/10, effective 1/1/11; **ARC 9350B**, IAB 2/9/11, effective 4/1/11]

These rules are intended to implement Iowa Code section 234.6.

441—47.3 to **47.20** Reserved.

DIVISION II
FAMILY SELF-SUFFICIENCY GRANTS PROGRAM

PREAMBLE

These rules define and structure the family self-sufficiency grants (FSSG) program provided through the PROMISE JOBS program. The purpose of the FSSG program is to provide immediate and short-term assistance to PROMISE JOBS participant families which will remove barriers related to obtaining or retaining employment. Removing the barriers to self-sufficiency might reduce the length of time a family

is dependent on the family investment program (FIP). Family self-sufficiency grants shall be available for payment to families or on behalf of specific families.
[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.21(239B) Definitions.

"Appropriate responsible administrator" means:

1. For the bureau of refugee services (BRS), the administrator of the department service area with the oversight for the bureau of refugee services, or the administrator's designee.

2. For Iowa workforce development (IWD), the administrator of the department of workforce development's division of workforce development center administration, or the administrator's designee.

"Bureau of refugee services" or *"BRS"* means a unit of the department of human services that provides PROMISE JOBS services to refugees.

"Candidate" means anyone expressing an interest in the family self-sufficiency grants program.

"Department" means the Iowa department of human services.

"Department division administrator" means the administrator of the department of human services division of adult, children and family services, or the administrator's designee.

"Family" means "assistance unit" as defined at rule 441—40.21(239B).

"Family investment program" or *"FIP"* means the cash grant program provided by 441—Chapters 40 and 41, designed to sustain Iowa families.

"Family self-sufficiency grants" means the payments made to specific PROMISE JOBS participants, to vendors on behalf of specific PROMISE JOBS participants, or for services to specific PROMISE JOBS participants.

"Immediate, short-term assistance" means that assistance provided under this division shall be authorized upon determination of need and that it shall not occur on a regular basis.

"Iowa workforce development (IWD)" means the agency that develops and administers employment, placement and training services in Iowa and is contracted by the department to administer PROMISE JOBS services statewide.

"IWD service delivery area" means the Iowa workforce development service delivery areas designated to provide PROMISE JOBS services.

"Local plan for family self-sufficiency grants" means the written policies and procedures for administering the grants for families as set forth in the plan developed by the PROMISE JOBS IWD service delivery area or BRS as described in rule 441—47.26(239B).

"Participant" means anyone receiving assistance under this division.

"PROMISE JOBS agreement" means the agreement between the division of adult, children and family services and the division of field support regarding delivery of PROMISE JOBS services to refugees.

"PROMISE JOBS contract" means the agreement between the department and Iowa workforce development regarding delivery of PROMISE JOBS services.

"PROMISE JOBS participant" means any person receiving services through PROMISE JOBS. A PROMISE JOBS participant must be a member of an eligible FIP household.

"Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program" means the department's work and training program as described in 441—Chapter 93.
[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.22(239B) Availability of the family self-sufficiency grants program. The family self-sufficiency grants program shall be available statewide.

47.22(1) The program shall be available for use by the IWD service delivery areas. Under the PROMISE JOBS contract, Iowa workforce development (IWD) shall allocate the funds available for authorization to each of the service delivery areas based on the allocation standards used for PROMISE JOBS service delivery purposes.

47.22(2) The program shall be available for use by the bureau of refugee services (BRS) for PROMISE JOBS participants who are refugees as delineated in the PROMISE JOBS agreement.

47.22(3) The division of funds between IWD and BRS will be negotiated based on the number of PROMISE JOBS families receiving services from each agency and history of use.

47.22(4) The department retains the funds which are released through the PROMISE JOBS expense allowance authorization system.

[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.23(239B) General criteria. Family self-sufficiency grants candidates shall be PROMISE JOBS participants. Participation in the family self-sufficiency grants program is voluntary and shall be based on an informed decision by the family. Further, candidates must have identifiable barriers to obtaining or retaining employment that can be substantially addressed through the assistance offered by family self-sufficiency grants.

441—47.24(239B) Assistance available in family self-sufficiency grants. Family self-sufficiency grants shall be authorized for removing an identified barrier to self-sufficiency when it can be reasonably anticipated that the assistance will enable PROMISE JOBS participant families to retain employment or obtain employment in the two full calendar months following the date of authorization of payment. For example, if a payment is authorized on August 20, it should be anticipated that the participant can find employment in September or October.

47.24(1) *Employment does not occur.* If employment does not occur in the anticipated two-calendar-month period or if the participant loses employment in spite of the self-sufficiency grant, no penalty is incurred and no overpayment has occurred.

47.24(2) *Types of assistance.* The department, in conjunction with IWD and BRS, shall determine those barriers to self-sufficiency which can be considered for family self-sufficiency grants such as, but not limited to, auto maintenance or repair, licensing fees, child care, and referral to other resources, including those necessary to address questions of domestic violence. The IWD service delivery areas and BRS shall have the opportunity to adjust the list of approvable barriers to self-sufficiency based on local resources and circumstances. These adjustments shall be approved by the division administrator and the appropriate responsible administrator prior to implementation.

47.24(3) *Limit on assistance.* The total payment limit per family is $1,000 per year. A year for a family shall be the 12 fiscal months following the date of authorization of the initial payment for the family. A fiscal month begins and ends in different calendar months.

47.24(4) *Frequency of assistance.* Family self-sufficiency grants are intended to provide immediate and short-term assistance and must meet the criteria in this rule. While a family may be a candidate more than once and may receive payments in consecutive months in some circumstances, payments shall not be established as regular or ongoing.

47.24(5) *Supplanting.* Family self-sufficiency grants shall not be used for services already available through department, PROMISE JOBS, or other local resources at no cost.

47.24(6) *Relationship to the family investment agreement.* Family self-sufficiency grants are separate from the PROMISE JOBS family investment agreement process. While the family investment agreement must be honored at all times and renegotiated and amended if family circumstances require it, no family shall be considered to be choosing the limited benefit plan if the family chooses not to participate in the family self-sufficiency grant program.

47.24(7) *Issuing payments.* Family self-sufficiency grants are PROMISE JOBS benefits and shall be authorized through the PROMISE JOBS expense allowance system. Warrants may be issued to the participants or to a vendor for support services provided to the family. The division administrator in conjunction with the appropriate responsible administrator shall have discretion in determining method of payment. The IWD service delivery area or BRS shall have the opportunity to adjust these payment options in an individual case based on circumstances and needs of the family with the approval of the division administrator and the appropriate responsible administrator prior to implementation.

[**ARC 8259B**, IAB 11/4/09, effective 12/9/09; **ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.25(239B) Application, notification, and appeals.

47.25(1) *Application elements.* Each IWD service delivery area shall use the established application form to be completed by the PROMISE JOBS participant and the PROMISE JOBS worker when the participant asks to be a candidate for a family self-sufficiency grant. The application form shall contain the following elements:

a. An explanation of family self-sufficiency grants and the expectations of the program.

b. Identification of the family and the person representing the family.

c. A clear description of the barrier to self-sufficiency to be considered.

d. Demonstration of how removing the barrier is related to retaining or obtaining employment, meeting the criteria from rule 441—47.24(239B).

e. Demonstration of why the other department, PROMISE JOBS, or community resources cannot deal with the barrier to self-sufficiency.

f. Anticipated cost of removing the barrier to self-sufficiency.

47.25(2) *Notification process.* PROMISE JOBS shall use Form 470-0602, Notice of Decision: Services, to notify the candidate of the PROMISE JOBS decision regarding the family self-sufficiency grant. Decisions shall be in accordance with policies of this division and the local plan.

a. On approval, the form shall indicate the amount of the benefit that will be issued to the candidate or paid to a vendor, or the service that will be provided to the family.

b. On denial, the form shall indicate the reason for denial.

47.25(3) *Appealable actions.* The PROMISE JOBS decisions on family self-sufficiency grants may be appealed pursuant to 441—Chapter 7. Copies of the local plan as described at rule 441—47.26(239B) shall be included with the appeal summary.

47.25(4) *Nonappealable actions.* PROMISE JOBS participants shall not be entitled to an appeal hearing if the sole basis for denying, terminating or limiting assistance from family self-sufficiency grants is that self-sufficiency grant funds have been reduced, exhausted, eliminated, or otherwise encumbered.

[**ARC 8259B**, IAB 11/4/09, effective 12/9/09; **ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.26(239B) Approved local plans for family self-sufficiency grants. Each IWD service delivery area shall create and provide to IWD the written policies and procedures for administering family self-sufficiency grants. BRS shall create and provide to the department the written policy and procedures for administering family self-sufficiency grants. The plan shall be reviewed for required elements and quality of service to ensure that it meets the purpose of the program and approved by the department division administrator and the IWD division administrator. The written policies and procedures shall be available to the public at county offices, PROMISE JOBS offices, and at IWD. At a minimum, these policies and procedures shall contain or address the following:

47.26(1) *A plan overview.* The plan overview shall contain a general description detailing:

a. Any types of services or assistance which will be excluded from consideration for family self-sufficiency grants by the IWD service delivery area or BRS.

b. How determinations will be made that the service or assistance requested meets the program's objective of helping the family retain employment or obtain employment.

c. How determinations will be made that the proposed family self-sufficiency grant is not supplanting as required at subrule 47.24(5).

d. Services established and any maximum (and minimum, if any) values of payments of the services established by the IWD service delivery area or BRS.

e. Verification procedures or standards for documenting barriers, using written notification policies found at 441—subrule 93.10(1).

f. Verification procedures or standards for documenting employment attempts if not already tracked by PROMISE JOBS procedures, using policies found at rule 441—93.10(239B).

g. How applications will be processed timely to address barriers to obtaining or retaining employment.

h. Follow-up procedures on participant effort.

i. Procedures for tracking of family self-sufficiency grant authorizations in order to stay within the amount allocated.

j. How staff will be trained to administer the program.

47.26(2) *Intake and eligibility determination.* The policies and procedures shall describe:

a. How families most likely to benefit from self-sufficiency grant assistance are identified.

b. How families can apply for self-sufficiency grant assistance.

c. How families will be informed of the availability of self-sufficiency grant assistance, its voluntary nature, and how the program works.

[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.27(239B) Evaluation of family self-sufficiency grants. The department, in conjunction with IWD and BRS, shall develop an evaluation plan. The evaluation plan shall:

1. Describe tracking procedures.
2. Describe the plan for evaluation (e.g., what elements will be used to create significant data regarding outcomes).
3. Describe how measurable results will be determined.
4. Identify any support needed to conduct an evaluation (e.g., what assistance is needed from the department and IWD).
5. Describe which aspects of the project were successful and which were not.

[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

441—47.28(239B) Recovery of FSSG overpayments. An overpayment exists when an item(s) for which the funds were awarded was not purchased, a duplicate payment was issued or when, according to receipts, the item(s) purchased costs less than the funds received. For purposes of overpayment and recovery, an FSSG payment is considered a PROMISE JOBS expense payment and is subject to rule 441—93.12(239B), recovery of PROMISE JOBS expense payments.

[**ARC 1147C**, IAB 10/30/13, effective 1/1/14]

These rules are intended to implement Iowa Code section 239B.11.

DIVISION III
PILOT COMMUNITY SELF-SUFFICIENCY GRANTS PROGRAM
Rescinded IAB 12/10/03, effective 1/1/04

DIVISION IV
PILOT POST-FIP DIVERSION PROGRAM
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CHAPTER 48
FAMILY INVESTMENT PROGRAM ELIGIBILITY UNDER SELF-EMPLOYMENT DEMONSTRATION PROJECTS

Rescinded IAB 4/2/03, effective 6/1/03

CHAPTER 49
TRANSITIONAL CHILD CARE ASSISTANCE PROGRAM

Rescinded IAB 10/3/01, effective 12/1/01

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 50]
[Prior to 2/11/87, Human Services[498]]

441—50.1(249) Definitions.

"Aged" shall mean a person 65 years of age or older.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Disabled" shall mean that a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months or can be expected to result in death. Exception: For the supplement for Medicare and Medicaid eligibles, being engaged in substantial gainful activity shall not preclude a determination of disability. A child under the age of 18 is disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity. For purposes of state-administered payments, the department shall determine disability according to rule 441—75.20(249A).

"Payment for a dependent relative" shall mean payment to a recipient on behalf of a dependent relative as defined in Iowa Code section 249.3(3).

"Payment for a protective living arrangement" shall mean payment to a recipient living in a family life home. The payment shall be made in accordance with standards established by the department by rule in 441—Chapter 52.

"Payment for residential care" shall mean payment to a recipient living in a residential care facility who is determined to be in need of care and payment is made on a per diem basis.

This rule is intended to implement Iowa Code section 249.3 as amended by 2004 Iowa Acts, House File 2134, section 4.

441—50.2(249) Application procedures.

50.2(1) In order to be eligible for state supplementary assistance, an aged, blind, or disabled person with need for a living arrangement as defined in Iowa Code section 249.3 shall be receiving supplemental security income benefits or shall meet all eligibility requirements for the benefits other than income, but have less income than the standards for the living arrangements as set forth in 441—Chapter 52 and 441—Chapter 177.

a. Payments for mandatory supplementation, blind allowance, dependent relative allowance, and the family life home program shall be federally administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit shall be excluded in determining eligibility for or the amount of the state payment.

b. Payments for in-home, health-related care and residential care shall be state administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit, except the $20 exclusion of any income, shall be excluded in determining eligibility for or the amount of the state payment.

c. Payments for supplements for Medicare and Medicaid eligibles shall be state-administered. Income excluded in determining eligibility for the person's Medicaid coverage group shall be excluded in determining eligibility for the state payment.

50.2(2) Any person applying for payment for a protective living arrangement or payment for a dependent relative shall make application for supplemental security income at the Social Security Administration district office. The county office of the department of human services shall certify to the Social Security Administration as to the nature of the living arrangement or the status of the dependent.

50.2(3) Any person applying for payment for residential care shall make application at a local office of the department of human services or at the residential care facility where the person resides. Any person applying for a dependent person allowance or for payment for a protective living arrangement or

in-home, health-related care shall make application at a local office of the department. An application may also be filed in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided.

The application shall be made on the Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or 470-0462(S). The application shall be signed by the applicant or the authorized representative. Someone acting responsibly for an incapacitated, incompetent, or deceased person may sign the application on the person's behalf.

a. Each individual wishing to do so shall have the opportunity to apply for assistance without delay.

b. An applicant may be assisted by other individuals in the application process; the client may be accompanied by the individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

c. The applicant shall immediately be given an application form to complete. When the applicant requests that the forms be mailed, the department shall send the necessary forms in the next outgoing mail.

d. The decision with respect to eligibility shall be based primarily on information furnished by the applicant. The department shall notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or refusal to authorize the department to secure the information from other sources shall serve as a basis for denial of assistance.

50.2(4) An application for Medicaid from a person who meets the requirements of rule 441—51.6(249) shall be considered as an application for the supplement for Medicare and Medicaid eligibles.

This rule is intended to implement Iowa Code section 249.4 as amended by 2004 Iowa Acts, House File 2134, section 5.

[**ARC 0544C**, IAB 1/9/13, effective 3/1/13]

441—50.3(249) Approval of application and effective date of eligibility.

50.3(1) Payment for a federally administered payment category when the applicant is not an SSI recipient shall be effective the month following the month that an application is filed or, if later, the month following the month that all eligibility criteria are met, pursuant to 42 U.S.C. 1382(c)(7).

Payment for a federally administered payment category when the applicant is an SSI recipient shall be effective as of the first day of the month in which an application is filed or the first day of the month in which all eligibility criteria are met, whichever is later, notwithstanding 42 U.S.C. 1382(c)(7).

50.3(2) Payment for residential care shall be effective as of the date that eligibility first exists, notwithstanding 42 U.S.C. 1382(c)(7), but in no case shall the effective date be earlier than 30 days prior to the date of application.

50.3(3) The application for residential care shall be approved or denied within five working days after the Social Security Administration approves supplemental security income benefits. When supplemental security income benefits will not be received, the application shall be approved or denied within five working days from the date of establishment of all eligibility factors.

50.3(4) Payment for the supplement for Medicare and Medicaid eligibles shall be effective retroactive to October 1, 2003, or to the first month when all eligibility requirements are met, whichever is later.

This rule is intended to implement Iowa Code section 249.4 as amended by 2004 Iowa Acts, House File 2134, section 5.

441—50.4(249) Reviews.

50.4(1) Any eligibility factor shall be reviewed whenever a change in circumstances occurs.

50.4(2) All eligibility factors shall be reviewed at least annually.

50.4(3) For purposes of an annual review to be performed by the department, Form 470-3118 or 470-3118(S), Medicaid Review, shall be completed.

50.4(4) Rescinded IAB 10/31/01, effective 1/1/02.

This rule is intended to implement Iowa Code section 249.4.

441—50.5(249) Application under conditional benefits. When the client is seeking state supplementary assistance (SSA) under the conditional benefit policy of the supplemental security income (SSI) program, the client shall be required to do the following:

50.5(1) Sign Form 470-2909, Agreement to Sell Excess Property, in order to be eligible.

50.5(2) 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 benefits 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.

50.5(3) Sign an agreement to repay the state supplementary assistance granted during the conditional period using Form 470-2835, State Supplementary Assistance Agreement to Repay Conditional Benefits. The amount of repayment is limited to the lesser of:

a. The amount by which the revised value of resources (resources counted at the beginning of the conditional period plus the net value of resources sold) minus both the resource limit and the amount that SSI recovers for conditional benefits.

b. The amount of state supplementary assistance actually paid in the conditional period, minus the amount that SSI recovers for conditional benefits.

This rule is intended to implement Iowa Code sections 249.3, 249.4 and 249A.4.

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CHAPTER 51
ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]
[Prior to 2/11/87, Human Services[498]]

441—51.1(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

This rule is intended to implement Iowa Code section 249.3.

441—51.2(249) Supplementation. Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity shall be considered as income, and the payment shall be used to reduce the state supplementary assistance payment.

441—51.3(249) Eligibility for residential care.

51.3(1) *Licensed facility.* Payment for residential care shall be made only when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections and appeals pursuant to laws governing health care facilities.

51.3(2) *Physician's statement.* Payment for residential care shall be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

51.3(3) *Income eligibility.* The resident shall be income eligible when the income according to 441—paragraph 52.1(3)*"a"* is less than 31 times the per diem rate of the facility. Partners in a marriage who both enter the same room of the residential care facility in the same month shall be income eligible for the initial month when their combined income according to 441—paragraph 52.1(3)*"a"* is less than twice the amount of allowed income for one person (31 times the per diem rate of the facility).

51.3(4) *Diversion of income.* Rescinded IAB 5/1/91, effective 7/1/91.

51.3(5) *Resources.* Rescinded IAB 5/1/91, effective 7/1/91.

This rule is intended to implement Iowa Code section 249.3.

441—51.4(249) Dependent relatives.

51.4(1) *Income.* Income of a dependent relative shall be less than $370. When the dependent's income is from earnings, an exemption of $65 shall be allowed to cover work expense.

51.4(2) *Resources.* The resource limitation for a recipient and a dependent child or parent shall be $2,000. The resource limitation for a recipient and a dependent spouse shall be $3,000. The resource limitation for a recipient, spouse, and dependent child or parent shall be $3,000.

51.4(3) *Living in the home.* A dependent relative shall be eligible until out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.4(4) *Dependency.* A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[**ARC 7605B**, IAB 3/11/09, effective 4/15/09; **ARC 9965B**, IAB 1/11/12, effective 1/1/12; **ARC 0064C**, IAB 4/4/12, effective 5/9/12; **ARC 0489C**, IAB 12/12/12, effective 1/1/13; **ARC 0633C**, IAB 3/6/13, effective 5/1/13; **ARC 1268C**, IAB 1/8/14, effective 1/1/14; **ARC 1352C**, IAB 3/5/14, effective 4/9/14]

441—51.5(249) Residence. A recipient of state supplementary assistance shall be living in the state of Iowa.

This rule is intended to implement Iowa Code section 249.3.

441—51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

51.6(1) *Medicaid eligibility.* The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spenddown or pay a premium to be eligible for medical assistance benefits.

51.6(2) *SSI eligibility.* The recipient shall meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.6(3) *Not otherwise eligible.* The recipient must not be eligible for benefits under another state supplementary assistance group.

51.6(4) *Medicare eligibility.* The recipient must be currently eligible for Medicare Part B.

51.6(5) *Living arrangement.* A recipient may live in one of the following:

a. The person's own home.

b. The home of another person.

c. A group living arrangement.

d. A medical facility.

51.6(6) *Income.* Income of a recipient shall be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

This rule is intended to implement Iowa Code section 249.3 as amended by 2005 Iowa Acts, House File 825, section 108.

441—51.7(249) Income from providing room and board. In determining profit from furnishing room and board or providing family life home care, $370 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

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441—51.8(249) Furnishing of social security number. As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

441—51.9(249) Recovery.

51.9(1) *Definitions.*

"Administrative overpayment" means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

"Agency error" means 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 local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former applicant or recipient of state supplementary assistance.

"Client error" means 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.

51.9(2) *Amount subject to recovery.* The department shall recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department also shall seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.9(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, when known; and the reason for the incorrect expenditure.

51.9(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

51.9(5) *Repayment.* The repayment of incorrectly expended state supplementary assistance funds shall be made to the department.

51.9(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

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CHAPTER 52
PAYMENT

[Prior to 7/1/83, Social Services[770] Ch 52]
[Prior to 2/11/87, Human Services[498]]

441—52.1(249) Assistance standards. Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted.

52.1(1) *Protective living arrangement.* The following assistance standards have been established for state supplementary assistance for persons living in a family life home certified under rules in 441—Chapter 111.

$783	Care allowance
$100	Personal allowance
$883	Total

52.1(2) *Dependent relative.* The following assistance standards have been established for state supplementary assistance for dependent relatives residing in a recipient's home.

a. Aged or disabled client and a dependent relative $1,091
b. Aged or disabled client, eligible spouse, and a dependent relative $1,452
c. Blind client and a dependent relative $1,113
d. Blind client, aged or disabled spouse, and a dependent relative $1,474
e. Blind client, blind spouse, and a dependent relative $1,496

52.1(3) *Residential care.* Payment to a recipient in a residential care facility shall be made on a flat per diem rate of $17.86 or on a cost-related reimbursement system with a maximum per diem rate of $29.66. The department shall establish a cost-related per diem rate for each facility choosing this method of payment according to rule 441—54.3(249).

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule shall be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care shall be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

(1) When income is earned, impairment related work expenses, as defined by SSI plus $65 plus one-half of any remaining earned income.

(2) An allowance of $100 to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry shall not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

b. Payment is made for only the days the recipient is a resident of the facility. Payment shall be made for the date of entry into the facility, but not the date of death or discharge.

c. Payment shall be made in the form of a grant to the recipient on a post payment basis.

d. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

e. Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence which exceeds the 30-day annual limit. This information shall be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, Form 470-0042, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions at rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

f. Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

g. The per diem rate established for recipients of state supplementary assistance shall not exceed the average rate established by the facility for private pay residents.

(1) Residents placed in a facility by another governmental agency are not considered private paying individuals. Payments received by the facility from such an agency shall not be included in determining the average rate for private paying residents.

(2) To compute the facilitywide average rate for private paying residents, the facility shall accumulate total monthly charges for those individuals over a six-month period and divide by the total patient days care provided to this group during the same period of time.

52.1(4) *Blind.* The standard for a blind recipient not receiving another type of state supplementary assistance is $22 per month.

52.1(5) *In-home, health-related care.* Payment to a person receiving in-home, health-related care shall be made in accordance with rules in 441—Chapter 177.

52.1(6) *Minimum income level cases.* The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions which were in effect in October 1972 shall be utilized.

52.1(7) *Supplement for Medicare and Medicaid eligibles.* Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be $1 per month.

This rule is intended to implement Iowa Code chapter 249.

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CHAPTER 53
RENT SUBSIDY PROGRAM

Rescinded IAB 10/8/08, effective 11/12/08

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CHAPTER 54
FACILITY PARTICIPATION

[Prior to 7/1/83, Social Services[770] Ch 54]
[Prior to 2/11/87, Human Services[498]]

441—54.1(249) Application and contract agreement. Each facility desiring to participate in the state supplementary assistance program must enter into a contract with the department of human services and agree to the provisions as enumerated in Form 470-0443, Application and Contract Agreement for Residential Care Facilities. The effective date of the contract shall be the first of the month that the Application and Contract Agreement for Residential Care Facilities, signed by the administrator of the facility, is received by the department. No payment shall be made for care provided before the effective date of the contract. The contract shall be in effect until the department ceases to participate in the program, until either party gives 60 days' notice of termination in writing to the other party, or until there is a change in ownership. The facility shall notify the department within 30 days of a change in ownership, a change in the number of beds or a change in administrator.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 0991C**, IAB 9/4/13, effective 11/1/13]

441—54.2(249) Maintenance of case records. A facility must maintain a case folder for each individual residing in the facility which contains the following:

1. Contract between the facility and the resident on Form 470-0477, RCF Admission Agreement.
2. Physician's statement certifying that the resident does not require nursing services.
3. Proof of expenditures from resident's "personal needs" allowance.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 0991C**, IAB 9/4/13, effective 11/1/13]

441—54.3(249) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. The reports shall be based on the following rules.

54.3(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 54.8(1).

54.3(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 basis.

54.3(3) *Submission of reports.* The report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than three months after the close of the facility's established fiscal year. If the residential care facility is associated with a nursing facility, the cost report shall be due no later than five months after the close of the provider's reporting year.

a. The financial and statistical report shall be submitted in an electronic format approved by the department.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the residential care facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 54.3(3)*"d."*

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

d. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the fourth month following the facility's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments shall be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

e. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

f. When a residential care facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

54.3(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report was received by the department of human services. Adjustments shall be included in the payment the third month after the receipt of the report.

54.3(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.

54.3(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.

54.3(7) *Patient days.* In determining in-patient 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.

54.3(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.

54.3(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a recipient is on a reserved bed status and the department of human services 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 resident and a per diem rate for the bed is charged to any party, reserved days shall be included in the total census figures for in-resident days.

54.3(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, and such services as supervision, feeding, and similar services.

b. Revenue not related to resident care shall be applied in reduction of the related expense.

c. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

d. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

54.3(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing resident care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. 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 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and 761—Chapter 910 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) to (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 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 is an allowable cost, provided the services are actually performed in a necessary function. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of

these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 54.3(3)*"d."*

(2) Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable facilities, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner 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 facility.

(4) The maximum allowed compensation for the administrator is $1,250 per month plus $13 per month per bed licensed capacity for each bed over 60 not to exceed $1,775 per month.

(5) The maximum allowed compensation for employees as set forth in subparagraph 54.3(11)*"h"*(4) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the residential care facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees shall be computed on the same basis as the administrator's salary but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, such costs are allowed.

j. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated normal life of the asset, may be included as a resident cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to 54.3(12)*"b"* and *"c."*

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 resident care.

(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 such 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 resident 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 resident care ordinarily furnished directly to residents by such institutions; and that the charge to the facility is in line with the charge for these services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for these 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 or lease expense allowable on the cost report shall be based on either of the following methods at the discretion of the operator:

(1) Actual rent expense or portion thereof so that total property cost does not exceed the median property cost of all participating facilities as adjusted annually based on cost reports on file with the department as of June 30 each year.

(2) The cost of the facility amortized over its expected useful life plus other owner's expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents or leases the building from a related party, the amount of rent or lease expense allowable on the cost report shall be no more than the amortized cost of the facility plus other owner's expenses.

Whenever owner's costs are used as the basis for allowable rental costs, the owner must be willing to provide documentation of these costs.

n. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

o. Penalties or fines imposed by federal or state agencies are not allowable expenses.

p. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

54.3(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 shall be made until formal notification is received. The following situations are defined as transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the residential care program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, in whole or in part, a transfer of ownership is considered to have taken place.

b. Upon change of ownership, the new owner or operator shall furnish the department with an appraisal made by a department-approved appraiser. The appraisal shall be based on market values.

c. The new owner or operator shall either continue the previous owner's depreciation schedule or set up a new depreciation schedule using the amount obtained by deducting the depreciation expense incurred since July 1, 1980, from the value of depreciable real property. The value will be the sale price or appraisal value, whichever is less.

54.3(13) *Payment to new home.* A new home for which cost has not been established shall receive the prevailing maximum allowable cost ceiling. At the end of three months' operation a financial and statistical report shall be submitted. Subsequent reports shall be submitted from the first day to the last day of the fiscal year.

54.3(14) *Payment to the new owner.* An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established. The facility shall submit a report for the period from beginning of actual operation to the end of the fiscal year.

54.3(15) *Basis for reimbursement and upper limits.* The cost-related per diem rate is calculated by computing the per diem allowable costs from the financial and statistical report, adding an inflation factor on an annual basis to all costs except interest to adjust for inflation, and adding an incentive factor of 52 cents for nonprofit facilities and 70 cents for proprietary facilities. The inflation factor shall not exceed the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

A facility's actual allowable costs when combined with the inflation and incentive factors must not exceed the upper limit established in 441—subrule 52.1(3).

This rule is intended to implement Iowa Code section 249.12 and 1992 Iowa Acts, chapter 1241, section 33, subsection 3.

[**ARC 0991C**, IAB 9/4/13, effective 11/1/13]

441—54.4(249) Goods and services provided. All facilities participating in the program shall provide residents those goods and services required by the terms of the license issued by the department of inspections and appeals in accordance with Iowa Code chapter 135C and rules promulgated thereto set forth in 481—Chapter 57 and requirements of the department of human services set forth in these rules.

54.4(1) *Payment accepted.* The amount of client participation and the payment made through the state supplementary assistance program shall be accepted as payment in full for the required goods and services provided the resident. The facility may seek reimbursement from other sources for goods and services provided that are beyond the goods and services required to be provided by these rules.

54.4(2) *Care, maintenance, general supervision, and personal services.* Each facility as part of providing care, maintenance, general supervision, and personal services shall provide as necessary supervision or assistance with ambulation, grooming, hair washing, shaving, personal hygiene, bathing, getting in and out of bed, dressing, feeding, and with medication that can be self-administered.

54.4(3) *Laundry.* Each facility shall provide personal laundry service to the resident as part of the goods and services paid for through the program.

54.4(4) *Room furnishings.* The facility shall completely furnish the resident's room in accordance with department of inspections and appeals 481—subrule 57.30(4) without additional charge to the resident or person acting on the resident's behalf. When the resident wishes to provide some item or items of room furnishing, the facility may grant the request.

This rule is intended to implement Iowa Code section 249.12.

441—54.5(249) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The personal needs funds shall be deposited in a single checking account, not commingled with trust funds from any other facility, nor commingled with facility operating funds except for facility funds, not to exceed $500, deposited to cover bank charges and have in the account name the terms "Resident Trust Funds." The funds shall be deposited in a bank or other institution within the state of Iowa insured by the federal government. Expense for bank service charges for this account is an allowable audit cost under rule 441—54.3(249) 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 such 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 Iowa department of human services, and shall meet the following criteria:

54.5(1) *Ledger.* 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.

54.5(2) *Expenditures.* When something is purchased for the resident and is not a direct cash disbursement, each such 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.

54.5(3) *Disbursement.* Personal funds shall be turned over only 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 the 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.

54.5(4) *Audit.* The ledger and receipts for each recipient 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.

54.5(5) *Death.* Upon a recipient's death the funds remaining in the personal needs account shall be treated in the following manner:

a. The facility shall provide a written statement of the personal needs account to be filed in the case record.

b. When an estate is opened, the funds shall be submitted to the estate administrator.

c. When no estate is opened, the funds shall be released to the person assuming responsibility for the recipient's funeral expenses.

d. When no estate is opened and there are no living heirs, the funds shall be submitted to the department to escheat to the state.

This rule is intended to implement Iowa Code section 249.12.

441—54.6(249) 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.

This rule is intended to implement Iowa Code section 249.12.

441—54.7(249) Billing procedures. In order to determine the amount of payment to the recipient, the facility shall submit a billing form to the Iowa Medicaid enterprise following the month in which service was provided.

54.7(1) *Billing.* When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The original shall be returned as a claim for the next month. Alternatively, the facility may use electronic billing software provided by the Iowa Medicaid enterprise.

54.7(2) *Changes.* When there has been a new admission, a discharge, or a claim for a reserved bed, the facility shall submit Form 470-0039 with the changes noted. Electronic submissions of changes may also be made as provided for by the Iowa Medicaid enterprise.

This rule is intended to implement Iowa Code section 249.12.

441—54.8(249) Audits.

54.8(1) *Audit of financial and statistical report.* Authorized representatives of the department of human services 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 conditions set forth in rule 441—54.3(249). These audits may be done either on the basis of an on-site visit to the facility, to the facility's central accounting office, or to an office of the facility's agent.

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 of human services that the indicated per diem 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 residential care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department of human services 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.

54.8(2) *Audit of proper billing and handling of resident 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 of

human services 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 resident funds in compliance with rule 441—54.5(249).

c. The auditor shall recommend and the department of inspections and appeals shall request repayment by the facility to either the department of human services or the resident(s) involved, 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. If the facility fails to comply with paragraph *"d,"* the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 0991C**, IAB 9/4/13, effective 11/1/13]

441—54.9 Rescinded IAB 8/9/89, effective 10/1/89.

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TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTER 55
WORK AND TRAINING PROGRAMS

[Prior to 7/1/83, Social Services[770] Ch 55]
[Prior to 2/11/87, Human Services[495]]

Rescinded, effective 7/1/89, see 441—Chapter 93

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTER 55
WORK AND TRAINING PROGRAMS
[Prior to 7/1/83, Social Services[770] Ch 55]
[Prior to 2/11/87, Human Services[495]]
Rescinded, effective 7/1/89, see 441—Chapter 93

CHAPTER 56
BURIAL BENEFITS

[Prior to 7/1/83, Social Services[770] Ch 56]
[Prior to 2/11/87, Human Services[498]]

Rescinded IAB 2/6/02, effective 4/1/02

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

"Department" means the Iowa department of human services.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

[**ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.2(29C) Program implementation.

58.2(1) *Disaster declaration.* The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a declaration of a state of disaster emergency that authorizes individual assistance. The program shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

58.2(2) *Voucher system.* The IIAGP will be implemented through a reimbursement or voucher system.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11; **ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.3(29C) Application for assistance. To request assistance for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the contracted administrative entity along with: (1) receipts for the claimed expenses or (2) a request to participate in a voucher system.

58.3(1) Application forms are available from an approved administrative entity, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application shall include:

a. A declaration of the household's annual income, accompanied by:

(1) A current pay stub, W-2 form, or income tax return, or

(2) Documentation of current enrollment in an assistance program administered by the department, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or other subsidy program.

b. An authorization to release confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

f. A short, handwritten narrative of how the disaster event caused the claimed loss.

g. A copy of a picture identification document for each adult applicant.

h. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11; **ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income. Proof of income is required.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance or that are less than the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

[**ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is $5,000. Assistance is available under the program for the following disaster-related expenses:

58.5(1) Assistance may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, excluding appliances covered under subparagraph 58.5(1)*"d"*(8), up to a maximum of $560, including:

(1) Equipment and furnishings, up to a maximum of $560.

(2) Food, up to a maximum of $50 for one person plus $25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of $30 per person and $150 per household.

c. Clothing and bedroom furnishings, up to a maximum of $875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of $250 per person.

(2) Clothing, up to a maximum of $145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of $40.

(2) Dehumidifier, up to a maximum of $150.

(3) Sump pump (in a flood event only), up to a maximum of $200 installed.

(4) Electrical or mechanical repairs, up to a maximum of $1,000.

(5) Water heater, up to a maximum of $425 installed.

(6) Vehicle repair, up to a maximum of $500.

(7) Heating and air-conditioning systems, up to a maximum of $2,100 installed. Air conditioning is covered only with proof of medical necessity.

(8) Kitchen or laundry appliances up to a maximum of $700 per appliance and a maximum per household not to exceed $2,100.

58.5(2) Assistance may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of $5,000.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Assistance may be authorized for:

(1) The repair of structural components, such as the foundation and roof.

(2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

(3) Debris removal, including trees, up to a maximum of $1,000.

(4) Replacement or repair of other items of necessity as approved by the department on a case-by-case basis up to a maximum of $5,000.

c. Repairs to rental property or landlord-owned equipment are excluded under this program.

58.5(3) Assistance may be issued for temporary housing assistance, up to a limit of $50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

[**ARC 9312B**, IAB 12/29/10, effective 3/1/11; **ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.6(29C) Eligibility determination and payment.

58.6(1) The contracted administrative entity or designee shall confirm that the address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area. The department reserves the right to view the damaged property prior to providing any assistance pursuant to IIAGP.

58.6(2) Designated staff in the department shall:

a. Monitor applicants' names and addresses as reports are submitted by the administrative entity.

b. Monitor, review, and provide timely submission of invoices by the administrative entity for payment and shall process appeals.

58.6(3) For applications with a voucher or reimbursement request, the department or its designee shall:

a. Determine eligibility and the amount of payment within the rules of the program.

b. Notify the applicant household of the eligibility decision.

c. Authorize vouchers to an eligible household to purchase needed goods and services.

d. Pay vendors for goods and services purchased with vouchers.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11; **ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.*

a. The household may request reconsideration of decisions regarding eligibility and the amount of assistance awarded.

b. To request reconsideration, the household shall submit a written request to the DHS Office of the Director, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the letter notifying the household of the department's decision.

c. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

[**ARC 9312B**, IAB 12/29/10, effective 3/1/11; **ARC 1353C**, IAB 3/5/14, effective 5/1/14]

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the Iowa individual assistance grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) *Exhaustion of funds.* The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. *Partial payment.* Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. *Reserved funds.* A portion of allocated funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. *Untimely applications.* Applications received after the program is discontinued shall be denied.

These rules are intended to implement Iowa Code chapter 29C.

441—58.9 to **58.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]
Rescinded IAB 4/7/10, effective 5/12/10

441—58.21 to **58.40** Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

441—58.41(217) Purpose. The rules in this division are intended to allow the department to deliver services more effectively during or following a disaster emergency declared by state or federal officials. These rules temporarily supersede departmental rules that would otherwise apply, with the primary purpose of reducing barriers to accessing and receiving services that may result from the emergency. The rules shall be tailored to meet special circumstances that arise from a specific disaster emergency and shall be time-limited.

This rule is intended to implement Iowa Code section 217.6.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements. Normal scheduled reporting, review, recertification, redetermination, or similar requirements related to continued eligibility are amended as follows:

58.42(1) *Scheduled actions due in June 2008.* For the month of June 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in the most affected counties during the month. For all programs except food assistance, the designated counties are Black Hawk, Bremer, Butler, Johnson, and Linn.

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);

5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(2) *Scheduled actions due in July and August 2008.* For the months of July and August 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in any county of the state:

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(3) *Next scheduled action due.* For those households affected under subrules 58.42(1) and 58.42(2), the next report, review, recertification, or redetermination shall be scheduled as if the action due in June, July, or August 2008 had occurred. For example, if a six-month review was to have occurred in June 2008, the next review will be due in December 2008. Likewise, if a 12-month recertification was due in July 2008, the next recertification will be due in July 2009.

58.42(4) *Continuing to report and act on changes.* Other than as provided by this rule, households shall continue to comply with program requirements for reporting changes in circumstances. Good cause provisions for not reporting changes timely shall apply as provided by existing rules. The department shall continue to act on all changes reported or otherwise known to the department that may affect eligibility or benefits during the extended reporting, review, recertification and redetermination periods provided under this rule.

This rule is intended to implement Iowa Code chapters 234, 237A, 239B, 249, 249A, 249J, and 514I.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.43(237A) Need for child care services. State child care assistance eligibility requirements concerning need for service in rule 441—170.2(237A,239B) shall be held in abeyance for households residing in governor-declared disaster counties during the months of June, July, and August 2008. Households in those counties that previously met the requirement shall be considered to continue to meet the requirement for those three months if the disaster and ensuing recovery temporarily prevent the household from otherwise meeting this requirement.

This rule is intended to implement Iowa Code section 237A.13.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.44(249A,249J,514I) Premium payments. Individuals residing in any Iowa county declared by the governor to be a disaster area who would otherwise have their assistance under 441—Chapter 75 (medical assistance), 441—Chapter 86 (HAWK-I), or 441—Chapter 92 (IowaCare) canceled for failure to make a premium payment in the months of June or July 2008 shall not have their assistance canceled for this reason.

This rule is intended to implement Iowa Code chapters 249A, 249J, and 514I.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.45(249A) Citizenship and identity. Citizenship and identity requirements under 441—Chapter 75 for medical assistance applicants shall be held in abeyance for the months of June, July, and August 2008, for individuals residing in counties declared disaster areas by the governor as provided in this rule.

58.45(1) An affidavit may be used to establish both citizenship and identity when other forms of verification are not available and the department is unable to obtain verification through a match with vital records maintained by the department of public health.

58.45(2) An individual approved for medical assistance under this rule shall be granted a certification period of only three months. At the end of the three-month period, the individual shall be required

to provide documentation of citizenship and identity as otherwise required under 441—Chapter 75 to continue eligibility.

This rule is intended to implement Iowa Code chapter 249A.

[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.46 to **58.50** Reserved.

DIVISION IV
IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM

PREAMBLE

This division implements a program of state assistance to address unmet disaster-related expenses that cannot be met by other financial assistance. The program provides assistance for repair or replacement of personal property, home repair, food assistance, child care, and temporary housing to households whose income is less than 300 percent of the federal poverty level. The amount of assistance available to a household is capped at $2,500.

The program is administered by the department of human services in coordination with the rebuild Iowa office and local administrative entities designated by the county boards of supervisors.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.51(234) Definitions.

"Department" means the Iowa department of human services.

"Household" means all adults and children who lived in the pre-disaster residence who request individual assistance (not including landlords or other businesses), as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Local administrative entity" means a county-appointed fiscal entity that performs direct work with households seeking assistance for unmet needs. The local administrative entity certifies the assistance that each household may receive and issues direct reimbursement or purchase vouchers for certified goods or services.

"Unmet need" means an item or service needed to overcome a disaster-related hardship, injury, or adverse condition due to an eligible federally declared disaster resulting in costs or damages related to personal property, home repair, food assistance, child care, or temporary housing for which the household has not received adequate assistance from any federal, state, nonprofit, or faith-based agency.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.52(234) Program implementation. The Iowans helping Iowans unmet needs disaster assistance program shall be in effect September 15, 2010. This program is available for households affected by natural disasters in those areas identified by the President's Major Disaster Declaration for Individual Assistance, FEMA-1930-DR.

58.52(1) *Funding.* Funding for the program is established by the governor of Iowa through the Iowans helping Iowans program. The rebuild Iowa office will establish a methodology to distribute the funding among the counties in presidentially declared disaster areas.

58.52(2) *Local administration.* To implement the program, the county board of supervisors shall appoint a local administrative entity to administer the program for that county.

a. The local administrative entity may be, but is not limited to:

(1) A local community organization active in disaster (COAD),

(2) A local long-term recovery committee (LTRC),

(3) A nonprofit organization,

(4) A faith-based organization, or

(5) A regional or statewide LTRC.

b. The appointed local administrative entity shall enter into a contract with the department on Form FA 08-30-2010, Fiscal Agent Contract. The contract shall specify the terms for the administration of unmet needs benefits.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.53(234) Application for assistance. To request financial assistance for unmet disaster needs expenses, the household shall complete Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and submit the form to the local administrative entity.

58.53(1) Application forms are available from the local administrative entity. Individuals can find their local administrative entity by calling the rebuild Iowa office toll-free at (866)849-0323.

58.53(2) The application shall include:

a. A declaration of the household's annual gross income.

b. A release of confidential information to personnel involved in administering the program.

c. An assurance that the household had no insurance coverage for claimed items or services.

d. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration.

e. A copy of a photo identification document for each adult applicant.

f. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.54(234) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.54(1) The household's residence was located in the disaster area identified by a presidential declaration as described in rule 441—58.52(234), and the household verifies occupancy at that residence.

58.54(2) Household members are citizens of the United States or are legally residing in the United States.

58.54(3) The household's self-declared annual income is at or less than 300 percent of the federal poverty level for a household of that size.

a. Poverty level guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.54(4) The household has disaster-related expenses not covered by insurance, or the claim is less than or equal to the deductible amount. This program shall not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.54(5) The household has not previously received assistance from this program or another program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration, for the same loss. The applicant has applied with the Small Business Administration and the Federal Emergency Management Administration but did not receive an award for the items or services included in the unmet needs application.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.55(234) Eligible categories of assistance. The maximum assistance available to a household for a single disaster is $2,500. Assistance is available under the program for the following disaster-related expenses:

1. Personal property.
2. Home repair.
3. Food assistance.
4. Child care.

5. Temporary housing.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.56(234) Eligibility determination and payment.

58.56(1) *Duties of local administrative entity.* The local administrative entity shall perform the following duties:

a. Accept the household's application.

b. Certify that:

(1) The address provided on the application is a valid address in the disaster-affected area,

(2) Disaster-related expenses were a result of the covered disaster,

(3) The household has presented reasonable documentation or receipts for expenses incurred or has reasonable estimates for eligible costs for issuance of a voucher to secure specific eligible goods or services, and

(4) Funds remain available.

c. Determine the amount of assistance the household is eligible to receive by category of assistance and provide the rationale for that amount.

d. Provide the signature of local administrative entity staff making the certification and the date of certification.

e. Notify the applicant household of the certification decision and issue to an approved household:

(1) Reimbursement for documented expenses, or

(2) A voucher to secure specific eligible goods or services.

f. Retain a copy of the household's Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and all documentation.

g. Report weekly to the rebuild Iowa office regarding expenditures. Weekly reports shall be in the format prescribed in the agreement.

h. Complete a final reconciliation to substantiate expenditures.

i. Return any unexpended funds to the department within 30 days of the final expenditure or June 30, 2011.

58.56(2) *Local administrative expenses.* A local administrative entity may allocate no more than 5 percent of the amount of assistance provided to households as an administrative expense. Administrative expenses shall be detailed on the weekly report of expenditures.

58.56(3) *Duties of disaster case management office.* Designated staff in the rebuild Iowa disaster case management office shall:

a. Ensure that a local administrative entity is designated in each county affected.

b. Coordinate contact between applicants and their local administrative entity.

c. Support the reconsideration process.

58.56(4) *Duties of the department.* Designated department staff shall:

a. Process grant payments to the local administrative entity or its designee.

b. Process appeals.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.57(234) Contested cases.

58.57(1) *Reconsideration.* The household may request reconsideration of the local administrative entity's decision regarding certification of eligible unmet needs and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the Rebuild Iowa Office, Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa 50319, within 15 days of the date of the local administrative entity's notification to the household of its decision.

b. The rebuild Iowa disaster recovery case management office shall:

(1) Review any additional evidence or documentation submitted,

(2) Issue a reconsideration decision within 15 days of receipt of the request, and

(3) Notify the household of the reconsideration decision.

58.57(2) *Appeal.* The household may appeal the rebuild Iowa office reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted:

(1) In writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information;

(2) To the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114;

(3) Within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.58(234) Discontinuance of program. The Iowans helping Iowans unmet needs disaster assistance program administered under this division shall be discontinued upon exhaustion of allocated funds or on June 30, 2011, whichever occurs first.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

These rules are intended to implement Iowa Code section 234.6.

441—58.59 and **58.60** Reserved.

DIVISION V
TICKET TO HOPE PROGRAM

PREAMBLE

This division implements the ticket to hope program, a mental health counseling program funded through a social services emergency disaster relief grant that was authorized by Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009. The program pays for professional mental health evaluation and treatment services for individuals and families who have been affected by the weather-related disasters of 2008.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.61(234) Definitions.

"Department" means the Iowa department of human services.

"Ticket to hope" means the mental health counseling program for individuals and families who have been directly affected by the weather-related disasters of 2008.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.62(234) Application process. The process for obtaining assistance from the ticket to hope program is as follows:

58.62(1) A person requesting assistance shall contact the Iowa concern hotline by telephone at 1-800-447-1985.

58.62(2) The Iowa concern hotline shall gather information and determine eligibility for ticket to hope services based on criteria established in this division.

58.62(3) The Iowa concern hotline shall send to each eligible applicant a packet of information that includes:

a. An introductory cover letter;

b. A list of participating providers;

c. An authorization form for one 45- to 50-minute session (valid for 30 days); and

d. A demographic data form that includes a unique numeric client identifier.

58.62(4) The eligible applicant shall:

a. Make an appointment with an approved provider; and

b. Give the authorization and demographic data forms to the provider at the time of the appointment.

58.62(5) After the eligible applicant meets with the provider, the applicant may call the Iowa concern hotline and receive authorization for up to seven additional sessions. A new authorization form shall be issued for each session.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.63(234) Eligibility criteria. To be eligible for assistance, a person living in Iowa must report:

1. That the impact of the 2008 disaster has impaired the person's ability to carry out normal daily functions to some extent; and
2. That the person has no insurance coverage for mental health services, or has insurance with a high deductible that will deter the person from accessing necessary mental health services.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.64(234) Provider participation. A mental health professional with an active professional license issued by the Iowa department of public health who is qualified to provide individual psychotherapy (i.e., Current Procedural Terminology code 90806, "individual psychotherapy, insight-oriented behavior modification or support, provided face to face with the patient in an office or outpatient setting") according to the Iowa Plan vendor requirements shall be allowed to participate as a ticket to hope provider.

58.64(1) A mental health professional applying to participate in the program shall submit a copy of the professional license to the Iowa concern hotline.

58.64(2) The mental health professional shall agree to the terms of participation in the ticket to hope program by:

a. Signing a professional services agreement with the department; and

b. Returning the signed agreement to the Iowa concern hotline.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.65(234) Provider reimbursement. A provider approved to participate shall be reimbursed as follows:

58.65(1) The provider shall submit a completed demographic data form and the authorization form to the Iowa concern hotline within 30 days after each completed session with an approved applicant.

58.65(2) The provider shall be reimbursed at the lower of:

a. A rate of $93 per assessment or counseling session, or

b. The prevailing Iowa Medicaid rate.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.66(234) Reconsideration. An applicant may request reconsideration of a denial of access to services. A mental health professional may request reconsideration of a denial to be a part of the professional provider panel.

58.66(1) To request reconsideration, the person shall submit a written request to the DHS Division of Mental Health and Disability Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

58.66(2) The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days from receipt of the request.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.67(234) Appeal. The person may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

58.67(1) Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

58.67(2) A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.68(234) Discontinuance of program. The program shall end on June 30, 2010, or when the funds are expended, whichever occurs first.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 59
UNEMPLOYED PARENT WORKFARE PROGRAM

[Prior to 7/1/83, Social Services[770] Ch 59]

Rescinded, effective 7/1/89; see 441—Chapter 93

CHAPTER 60
REFUGEE CASH ASSISTANCE

[Prior to 9/24/86 IAC Supp., see Refugee Service 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define and structure the department's refugee cash assistance program. Eligibility criteria, application procedures, reasons for adverse action, payment procedures, and recoupment procedures for overpayments are outlined.

441—60.1(217) Alienage requirements.

60.1(1) *Immigration status.* A refugee is a person whose immigration status is one of the following statuses as issued by the United States Immigration and Naturalization Service:

a. Granted asylum under Section 208 of the Immigration and Nationality Act.

b. Admitted as a refugee under Section 207 of the Act.

c. Paroled as a refugee or asylee under Section 212(d)(5) of the Act.

d. Cuban and Haitian entrants in accordance with requirements in 45 CFR Part 401, as amended to March 22, 2000.

e. Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1988, as contained in Section 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Public Law 100-461).

f. Admitted for permanent residence, provided the individual previously held one of the statuses identified above.

60.1(2) *Nonrefugee child of refugee parents.* A nonrefugee child of refugee parents, when both parents in the home are refugees as defined in subrule 60.1(1), meets the alienage requirements. When only one parent is in the home and that parent is a refugee as defined in subrule 60.1(1), the child meets the alienage requirements.

60.1(3) *Immigration and Naturalization Service documents.* Each refugee shall provide Immigration and Naturalization Service documents in the form of either an I-94 card, an I-151 or I-551 card, or an I-181 card to support the immigration status defined in subrule 60.1(1). If the name of the resettlement agency which resettled the refugee is not on the document, the refugee shall provide the name of the resettlement agency.

441—60.2(217) Application procedures. Application policies are defined in rules 441—40.23 (239B), 441—40.24(239B), and 441—40.25(239B).

441—60.3(217) Effective date of grant. The date of eligibility for a grant is defined in rule 441—40.26(239B).

441—60.4(217) Accepting other assistance.

60.4(1) *Family investment program.* A refugee applicant or recipient shall accept a family investment program (FIP) grant if eligible under 441—Chapters 40 and 41.

60.4(2) *Supplemental security income (SSI).* Refugees who are 65 or older, blind, or disabled shall apply for and, if eligible, accept supplemental security income.

441—60.5(217) Eligibility factors.

60.5(1) *Age.*

a. An unmarried refugee is considered an adult at age 18, except as defined in 441—subrule 41.21(1), and is eligible to receive refugee cash assistance if otherwise eligible.

b. Married refugees with or without children, as defined in 441—subrule 41.21(1), are eligible regardless of age if other eligibility factors are met.

60.5(2) *Residency.* Residency requirements are defined in 441—subrule 41.23(1).

60.5(3) *Social security numbers.* Refugees are required to furnish a social security number as defined in 441—subrule 41.22(13).

60.5(4) *Determination of need.* Need shall be determined as defined in rule 441—41.28(239B) except as otherwise provided in this chapter.

60.5(5) *Income.* Income is defined in rules 441—40.21(239B) and 441—41.27(239B).

60.5(6) *Resources.* Resource requirements are defined in rule 441—41.26(239B).

441—60.6(217) Students in institutions of higher education. A refugee who is a full-time student in an institution of higher education (other than a correspondence school) is ineligible for assistance with two exceptions:

1. The refugee is in a program approved as part of an individual employability plan, as defined in subrule 60.9(3).
2. The refugee is in a program solely in English as a second language.

60.6(1) *Institution of higher education.* An institution of higher education is defined as an educational institution which provides an education program as specified below:

a. A public or private nonprofit institution of higher education is an educational institution which provides an educational program for which it awards an associate, baccalaureate, graduate, or professional degree; or at least a two-year program which is acceptable for full credit toward a baccalaureate degree; or at least a one-year training program which leads to a certificate or degree and prepares students for gainful employment in a recognized occupation.

b. A proprietary institution of higher education is an educational institution which provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

c. A postsecondary vocational institution is a public or private nonprofit educational institution which provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

60.6(2) *Full-time student.* A full-time student is a student who is carrying a full-time academic workload which equals or exceeds the following:

a. Twelve semester or 12 quarter hours per academic term in those institutions using standard semester, trimester, or quarter-hour systems.

b. Twenty-four semester hours or 36 quarter hours per academic year for institutions using credit hours to measure progress, but not using semester, trimester, or quarter systems, or the prorated equivalent for programs of less than one academic year.

c. Twenty-four clock hours per week for institutions using clock hours.

d. A series of courses or seminars which equals 12 semester hours or 12 quarter hours in a maximum of 18 weeks.

e. The work portion of a cooperative education program in which the amount of work performed is equivalent to the academic workload of a full-time student.

441—60.7(217) Time limit for eligibility. A refugee may receive assistance, if otherwise eligible, during the first eight months the refugee is in the United States, beginning the month the refugee enters the country. EXCEPTION: For asylees, the date of entry is the date asylum is granted. The eight-month period of eligibility begins the month asylum is granted. A nonrefugee child in the home with a refugee parent (or refugee parents, if both are in the home) is eligible for assistance until the parent(s) has been in the United States for eight months, or until the child reaches eight months of age, whichever occurs first.

60.7(1) *Resources.* The resources of refugees excluded because of the eight-month limit shall be considered in the same manner as though these refugees were included in the eligible group.

60.7(2) *Income.*

a. When the eligible refugee group has income, the income shall be diverted to meet the needs of the refugees ineligible because of the time limit who would otherwise have been included in the refugee assistance group as defined in subrule 60.5(4).

b. The income of the refugees ineligible because of the time limit who would otherwise have been included in the assistance group as defined in subrule 60.5(4), shall be used first to meet the needs of the ineligible group and then applied to the eligible group's needs.

c. The amount of need for the ineligible group is the difference between the needs of the group including the ineligible refugees and the needs of the group excluding the ineligible refugees. Any excess income shall be applied to the needs of the eligible group.

d. Any cash grant received by the applicant under the Department of State or the Department of Justice reception and placement programs shall be disregarded as income and as a resource.

441—60.8(217) Criteria for exemption from registration for employment services, registration, and refusal to register. Each refugee applying for or receiving cash assistance shall register for employment unless the department determines the refugee is exempt because of reasons listed in subrule 60.8(1). Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs and acceptance of appropriate offers of employment.

60.8(1) *Exemptions.* The following refugees are exempt from registration:

a. A refugee who is under the age of 16; or who is aged 16 but under the age of 18 and attending elementary, secondary, or vocational or technical school full-time; or a refugee who is enrolled full-time in training approved by the local office as part of an approved employability plan; or a refugee 18 years of age who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching the age of 19.

(1) A refugee shall be considered as attending school full time when enrolled or accepted full time (as certified by the school or institute attended) in a school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) The refugee also shall be considered in regular attendance in months when the refugee is not attending because of an official school or training program, vacation, illness, convalescence, or family emergency. A refugee meets the definition of regular school attendance until the refugee has been officially dropped from the school rolls.

(3) When the refugee's education is temporarily interrupted pending adjustment of the education or training program, assistance shall be continued for a reasonable period of time to complete the adjustment.

b. A refugee aged 65 or older.

c. A refugee who is caring for another member of the household who has a physical or mental impairment which requires, as determined by a physician or licensed or certified psychologist and verified by the department, care in the home on a substantially continuous basis, and no other appropriate member of the household is available.

d. A woman who is pregnant if it has been medically verified that the child is expected to be born in the month in which registration would otherwise be required or within the next six months.

e. A parent or other caretaker relative of a child under the age of three who personally provides full-time care for the child with only very brief and infrequent absences from the child. Only one parent or other caretaker relative in a case may be exempt under this paragraph. "Brief and infrequent absence" means short-term absences which do not reoccur on a regular basis. Any involvement by the parent employed less than 129 hours per month or attending school less than full-time, as defined by the school, shall be considered brief and infrequent. Recreational activities and vacations by the parent or child which result in the parent being absent from the child shall be considered brief and infrequent.

f. A refugee who is working at least 30 hours a week in unsubsidized employment expected to last a minimum of 30 days. This exemption continues to apply if there is a temporary break in full-time employment expected to last no longer than ten workdays.

g. A refugee who is ill, when determined by the department on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training.

h. A refugee who is incapacitated, when determined by a physician or licensed or certified psychologist and verified by the department, that a physical or mental impairment, by itself or in conjunction with age, prevents the refugee from engaging in employment or training.

60.8(2) *Registration.* A refugee not exempt under subrule 60.8(1) shall be considered an employable refugee. An employable refugee shall register with the department of employment services and, within 30 days of receipt of aid, participate in the employment services provided by the bureau of refugee services. The department does permit, but does not require, the voluntary registration for employment services of any applicant or recipient of refugee cash assistance who is exempt under the provisions of this rule. If a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the bureau of refugee services may deregister the refugee for up to 90 days from the date of determination that failure or refusal has occurred, but the refugee's cash assistance may not be affected.

60.8(3) *Refusal to register.*

a. An employable applicant refugee who refuses or fails to cooperate in accepting a referral to the department of employment services or the bureau of refugee services, refuses or fails to appear at the department of employment services office for registration, or refuses or fails to mail or deliver the registration form to the bureau of refugee services, shall be denied assistance.

b. Assistance for an employable recipient refugee shall be terminated when the refugee refuses or fails to register with the department of employment services or the bureau of refugee services.

441—60.9(217) Work and training requirements.

60.9(1) *Standards applicable to both work and training assignments.* The following standards must be met before an employable refugee can be required to accept a work or training assignment. A job offered, if determined appropriate under subrules 60.9(1) and 60.9(2), is required to be accepted by the refugee without regard to whether the job would interrupt a program of services planned or in progress unless the refugee is currently participating in a program in progress of on-the-job training or vocational training approved as part of an individual's employability plan or the refugee is enrolled full-time in a professional recertification program approved as part of an individual's employability plan.

a. The job or training referral must be related to the physical and mental capability of the person to perform the task on a regular basis. Any claim of adverse effect on physical or mental health shall be based on adequate medical testimony from a physician or licensed or certified psychologist indicating that participation would impair the person's physical or mental health.

b. The total daily commuting time to and from home to the work or training site to which the person is referred shall not normally exceed two hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance and time is generally accepted in the community, in which case the round trip commuting time shall not exceed the generally accepted community standards.

c. The work or training site to which the person is referred must not be in violation of applicable federal, state, and local health and safety standards.

d. Referrals shall not be made which are discriminatory in terms of age, sex, race, creed, color, or national origin.

e. When child care is required, the child care must meet state licensing or registration requirements.

f. Available manpower statistics for a local area must indicate adequate employment potential for persons obtaining the given training. The employment must also meet the other appropriate work requirements.

g. The work or training assignment must be within the scope of the refugee's employability plan.

h. The quality of training must meet local employers' requirements so that the refugee will be in a competitive position within the local labor market. The training must also be likely to lead to employment which will meet the appropriate work criteria.

i. If a refugee is a professional in need of professional refresher training and other recertification services in order to qualify to practice the refugee's profession in the United States, the training may

consist of full-time attendance in a college or professional training program, provided that the training is approved by the department as a part of the refugee's employability plan; it does not exceed one year's duration (including any time enrolled in the program in the United States prior to the refugee's application for assistance); it is specifically intended to assist the professional in becoming relicensed in the refugee's profession; and, if completed, it can realistically be expected to result in relicensing.

60.9(2) *Appropriate work requirements.* The local office, in making a determination of appropriate work, shall utilize the following criteria:

a. Appropriate work may be temporary, permanent, full-time, part-time, or seasonal work if it meets the other work standards defined in subrule 60.9(1).

b. The wage shall meet or exceed the federal or state minimum wage law, whichever is applicable, or if these laws are not applicable, the wage shall not be less favorable than the wage normally paid for similar work in that labor market but in no event shall it be less than three-fourths of the minimum wage rate.

c. The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

d. No person shall be required to accept employment if:

(1) The position offered is vacant due to a strike, lockout, or other bona fide labor dispute.

(2) The person would be required to work for an employer contrary to the conditions of the person's existing membership in the union governing that occupation. However, employment not governed by the rules of a union in which the person has membership may be deemed appropriate.

60.9(3) *Development of an individual employability plan.* An individual employability plan shall be developed as a part of a family self-sufficiency plan where applicable for each recipient of refugee cash assistance in a filing unit who is not exempt under 441—subrule 60.8(1). The individual employability plan shall:

a. Be designed to lead to the earliest possible employment and not be structured in such a way as to discourage or delay employment or job seeking.

b. Contain a definite employment goal, attainable in the shortest time period consistent with the employability of the refugee in relation to job openings in the area.

60.9(4) *Job search requirements.* The department shall require job search for employable refugees where appropriate.

a. An employable recipient of refugee cash assistance shall carry out a job search program beginning at any time required by the bureau of refugee services. The bureau of refugee services shall require the job search program to begin no later than six months after the refugee entered the United States or at the time the refugee is determined eligible for refugee cash assistance, if the refugee has completed at least six months in the United States at the time of the determination.

b. The job search program shall continue for at least eight consecutive weeks and shall meet requirements that the bureau of refugee services determines appropriate, including the amount of time to be devoted to employer contacts per week or the number of employer contacts required per week.

c. The department shall determine and carry out the procedures it considers necessary to ensure that requirements for participation in job search are met.

60.9(5) *Failure or refusal to accept employability services or employment.*

a. Unless the refugee is exempt as described at rule 441—60.8(217), the department shall terminate assistance when an employable recipient of refugee cash assistance has failed or refused to comply with any of the following requirements without good cause. The refugee shall:

(1) Register for employment with the department of employment services and, within 30 days of receipt of cash assistance, participate in employment services provided by the bureau.

(2) Apply for or accept an offer of employment meeting the standards above.

(3) Carry out job search.

(4) Go to a job interview arranged by the department or its designee.

(5) Participate in an employability service program which is determined to be available and appropriate for that refugee.

(6) Not voluntarily quit a job.

(7) Participate in a social service or targeted assistance program which the department determines to be available and appropriate for that refugee.

b. In cases of proposed action to terminate, discontinue, suspend, or reduce assistance, the department shall give timely and adequate notice, following the same procedures as those used in the family investment program. The written notice shall include:

(1) An explanation of the reason for the action and the consequences of failure or refusal.

(2) Notice of the refugee's right to file an appeal with the department. The department shall determine whether a hearing shall be granted.

c. For the first refusal or failure the refugee shall be sanctioned for three payment months. Subsequent refusals or failures shall result in a six-payment month sanction for each refusal or failure.

d. If the sanctioned individual is the only member of the filing unit, the assistance shall be terminated. If the filing unit includes other members, the department shall not take into account the sanctioned individual's needs in determining the filing unit's need for assistance. If the sanctioned individual is a caretaker relative, assistance provided to the other persons in the grant shall be made in the form of protective payments as defined in rule 441—43.22(239B).

e. A conciliation period prior to the imposition of sanctions must be provided for in accordance with the following time limitations. The conciliation effort shall begin as soon as possible, but no later than 10 days following the date of failure or refusal to participate, and may continue for a period not to exceed 30 days. Either the department or the recipient may terminate this period sooner when either believes that the dispute cannot be resolved by conciliation.

441—60.10(217) Uncategorized factors of eligibility.

60.10(1) *Duplication of assistance.* A refugee whose needs are included in a refugee cash assistance grant shall not concurrently receive a grant under any other public assistance program administered by the department. Neither shall a recipient concurrently receive a grant from a public assistance program in another state.

60.10(2) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive refugee cash assistance when the other party, obligated to provide the support, is able to fulfill that part of the contract.

60.10(3) *Participation in a strike.*

a. The spouse and children shall be ineligible for assistance for any month in which the other spouse or parent is participating in a strike on the last day of the month.

b. Any person shall be ineligible for assistance for any month in which the person is participating in a strike on the last day of that month.

c. Definitions of a strike and participating in a strike are defined in 441—subrule 41.25(5), paragraph *"c."*

60.10(4) Restrictions found in 441—subrule 41.25(11) apply to benefits issued under this chapter.

[**ARC 1207C**, IAB 12/11/13, effective 2/1/14]

441—60.11(217) Temporary absence from home. Temporary absence from home is defined in 441—subrule 41.23(3).

441—60.12(217) Application. The application shall be processed as defined in 441—40.22(239B).

441—60.13(217) Continuing eligibility. Continuing eligibility shall be determined as defined in rule 441—40.27(239B) except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

441—60.14(217) Alternate payees. Alternate payees are defined in 441—Chapter 43 except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

EXCEPTION: 441—subrule 43.22(1), paragraph *"c,"* shall not apply to refugee cash assistance applicants or recipients.

441—60.15(217) Payment. Payment shall be issued as defined in 441—Chapter 45 except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

441—60.16(217) Overpayment recovery. Recovery of overpayments shall be determined as defined in 441—Chapter 46, Division II, except that refugee cash assistance shall be substituted for the family investment program whenever it appears.
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These rules are intended to implement Iowa Code section 217.6.

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CHAPTER 61
REFUGEE SERVICES PROGRAM

[Prior to 9/24/86 IAC Supp., see Refugee Service Center 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The department of human services manages and coordinates refugee program activities in the state of Iowa. In this capacity, the department develops, implements, and oversees activities which reflect refugee policy priorities of the United States Department of State and the United States Department of Health and Human Services and which address sound practices on behalf of the state of Iowa as outlined in the Iowa state refugee program plan. Serving in the role of Iowa state refugee program coordinator, the director coordinates with resettlement agency administrators active in the resettlement of refugees within the state of Iowa. Although the department manages many activities and programs in the administration of the state of Iowa's refugee program, the central focus is to promote as expeditiously as possible economic self-sufficiency and social self-reliance for refugees.

These rules define and structure the department's refugee services program. Eligibility criteria, application procedures, reasons for adverse actions, and appeal procedures for clients and sponsors are outlined.

441—61.1(217) Definitions.

"Bureau" means the bureau of refugee services within the department.

"Bureau chief" shall mean the chief of the bureau of refugee services.

"Client" means refugees or others determined eligible for services funded under the refugee program.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services or a designee.

"Family self-sufficiency plan" means a plan that addresses the employment-related service needs of the employable members in a family for the purpose of enabling the family to become self-supporting through the employment of one or more family members. A family self-sufficiency plan shall be developed for anyone who receives employment-related services from the bureau.

"Iowa state refugee program coordinator" means the director, serving as the refugee program administrator, as appointed by the governor to administer programs funded and required by the Office of Refugee Resettlement within the United States Department of Health and Human Services.

"Iowa state refugee program plan" means the report that describes the state of Iowa's refugee program plan to meet the standards, goals, and priorities required under the Immigration and Nationality Act and developed by the bureau on the basis of a consultative process for the successful resettlement of refugees. The bureau chief must certify no later than 30 days after the beginning of each federal fiscal year that the approved plan is current and continues in effect. If the bureau wishes to change its plan, the bureau must submit a proposed amendment to the plan to be reviewed and approved or disapproved by the office of refugee resettlement.

"Legal proceeding" means any action before any court, or any legal action preparatory to appearing before any court, whether civil or criminal in nature.

"Office of refugee resettlement" means a federal agency within the United States Department of Health and Human Services with the legislative authority to be responsible for ensuring the coordination of federal resources in refugee resettlement.

"Portal-to-portal" means the span of time when interpreters leave their domicile or office to interpret at a scheduled interpreting assignment to interpret, and return to the domicile or office or arrive at their next interpreting assignment.

"Presiding judicial officer" means a judge of the United States, state, county, or municipal court, a magistrate, or judge in bankruptcy.

"Refugee" means any person who:

1. Is outside any country of the person's nationality or, in the case of a person having no nationality, is outside any country in which the person last habitually resided; and

2. Is unable or unwilling to return to that country and unable or unwilling to avail himself or herself of the protection of that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, as defined under the Immigration and Nationality Act, Title I, Section 101.

"Refugee unit" means either an individual refugee or two or more refugees representing an identifiable group, as determined by the bureau of refugee services.

"Resettlement agency" means any business, organization or group of related persons having a current contract with the U.S. Department of State's Bureau for Refugee Programs for the resettlement of refugees within the United States of America.

"Unaccompanied refugee minor (URM)" means a person who has not yet attained 18 years of age who entered the United States unaccompanied by and not destined to (1) a parent, or (2) a close non-parental adult relative who is willing and able to care for the child, or (3) an adult with a clear and court-verifiable claim to custody of the minor, and who has no parents in the United States.

441—61.2(217) Authority. The department has been given authority to administer the refugee program by Executive Order Number 21, signed by the governor December 24, 1985. U.S. Department of State and U.S. Department of Health and Human Services rules govern various program operations.

441—61.3(217) Eligibility for refugee services. Refugees eligible for services under this chapter include people who have one of the following statuses, as issued by the United States Immigration and Naturalization Service:

61.3(1) A person granted asylum under the Immigration and Nationality Act, Title II, Chapter 1, Section 208. Asylees are people who travel to the United States on their own and apply for and receive a grant of asylum.

61.3(2) A person admitted to the United States as a refugee under the Immigration and Nationality Act, Title II, Chapter 1, Section 207.

61.3(3) A person granted humanitarian parole as a refugee or asylee under the Immigration and Nationality Act, Title II, Chapter 2, Section 212. The United States Attorney General may, in the Attorney General's discretion, parole into the United States temporarily, under such conditions as the Attorney General may prescribe on a case-by-case basis, for urgent humanitarian reasons or significant public benefit, any alien applying for admission to the United States.

61.3(4) A Cuban or Haitian entrant in accordance with requirements in 45 CFR Part 401, as amended to March 22, 2000. Cuban and Haitian entrants include:

a. Any person granted parole status as a "Cuban/Haitian Entrant (Status Pending)" or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the person's status at the time assistance or services are provided; and

b. Any other national of Cuba or Haiti who meets both of the following conditions:

(1) The person either:

1. Was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act; or

2. Is the subject of exclusion or deportation proceedings under the Immigration and Nationality Act; or

3. Has an application for asylum pending with the Immigration and Naturalization Service.

(2) A final, nonappealable, and legally enforceable order of deportation or exclusion has not been entered with respect to the person.

61.3(5) A child born in Vietnam between January 1, 1962, and January 1, 1976, of an American citizen father and a Vietnamese mother, together with the child's immediate relatives, who are admitted to the United States as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1988, as contained in Section 101(e) of Public Law 100-202 and amended by the ninth proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Public Law 100-461).

61.3(6) A person admitted to the United States for permanent residence, provided the person previously held one of the statuses identified in subrules 61.3(1) through 61.3(5).

61.3(7) An alien immigrant who is a victim of a severe form of trafficking in persons, as certified by the United States Department of Health and Human Services pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000, as contained in Public Law 106-386, Division A, 114 Stat. 1464 (2000). "Severe forms of trafficking in persons" means:

a. Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform the act has not attained 18 years of age; or

b. The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

441—61.4(217) Planning and coordinating the placement of refugees in advance of their arrival. The director, or the director's designee, shall ensure that meetings are convened, no less often than quarterly, whereby representatives of local affiliates of voluntary resettlement agencies, local community service agencies, and other agencies that serve refugees meet with representatives of state and local governments to plan and coordinate the appropriate placement of refugees in advance of the refugees' arrival.

441—61.5(217) Services of the department available for refugees. All services provided to the refugee and family have self-sufficiency as the goal. Direct and contracted services may include, but are not limited to, the following:

61.5(1) *Job development.* These services involve working with employers in job development, placement, training, retention, and upgrading.

61.5(2) *Social adjustment.* These services include assessment and short-term counseling to persons or families in a perceived crisis, referral to appropriate resources, the making of arrangements for necessary services, home management services, transportation, translation and interpretation services, and case management services.

61.5(3) *Health-related services.* These services include information, referral to appropriate resources, assistance in scheduling appointments and obtaining services, and counseling to individuals or families to help them understand and identify their physical and mental health needs and maintain or improve their physical and mental health.

61.5(4) *Resettlement services.* These services involve securing and training sponsors, arranging for refugees to resettle in Iowa and providing case management, employment services, and social adjustment services.

As required under the resettlement contract with the U.S. Department of State, the department provides case management, employment services, and social adjustment services to the refugees it resettles during their first 90 days in Iowa.

61.5(5) *Any additional service.* These services, upon submission to and approval of the director of the office of refugee resettlement, include any additional service aimed at strengthening and supporting the ability of a refugee individual, family, or refugee community to achieve and maintain economic self-sufficiency, family stability, or community integration which has been demonstrated as effective and is not available from any other funding source.

61.5(6) *Information and publication.* These services provide information to Iowans about Iowa's refugee program, the refugees in Iowa, and their cultures.

61.5(7) *Bilingual publication.* These services provide refugees with publications in English as well as their native languages which assist in their successful resettlement.

61.5(8) *Translation and interpretation services.* These services provide interpreter service from English into the refugee languages or vice versa and assistance in translating written materials.

61.5(9) *Immigration services.* These services provide information and assistance to refugees in securing permanent resident alien status and family reunification.

61.5(10) *Adjustment of status.* These services provide guidance in obtaining permanent alien status and citizenship.

61.5(11) *Employability services.* These services are specifically designed to assist refugees to obtain employment and to improve the employability of work skills of the individual and include job referral to, and job placement with, private employers. Specific employability services include, but are not limited to, the following:

a. Employment services which include such activities as the development of a family self-sufficiency plan, world-of-work and job orientation, job clubs, job workshops, job development, referral to job opportunities, job search, and job placement and follow-up.

b. Employability assessment services which include such activities as aptitude and skills testing.

c. English language instruction which includes referrals to programs which offer a curriculum which places an emphasis on English as it relates to obtaining and retaining a job and to programs which are provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

d. On-the-job training which includes referrals to training that is provided at the employment site and is expected to result in full-time, permanent, unsubsidized employment with the employer who is providing the training.

e. Vocational training which includes referrals to driver education and training when provided as part of a family self-sufficiency plan.

f. Skills recertification which includes referrals to training that meets the criteria for appropriate training as provided for in paragraph *"b."*

g. Day care which includes referrals to day care for children necessary for participation in an employability service or for the acceptance or retention of employment.

h. Transportation when necessary for participation in an employability service or for the acceptance or retention of employment.

i. Translation and interpretation services when necessary in connection with employment or participation in an employability service.

j. Case management services for refugees who are considered employable and for recipients of public assistance who are considered employable, provided that the services are directed toward a refugee's attainment of employment as soon as possible after arrival in the United States.

k. Assistance in obtaining employment authorization documentations (EADs).

61.5(12) *Outreach services.* These services include activities designed to familiarize refugees with available services, to explain the purpose of these services, and to facilitate access to these services.

61.5(13) *Referral.* These services enable referral of refugee clients to mainstream service systems.

441—61.6(217) Provision of services.

61.6(1) *Priority of services.* Services are provided to refugees in the following order of priority, except in certain individual extreme circumstances:

a. All newly arriving refugees during their first year in the United States, who apply for services.

b. Refugees who are receiving cash assistance.

c. Unemployed refugees who are not receiving cash assistance.

d. Employed refugees in need of services to retain employment or to attain economic independence.

61.6(2) *Limitations on eligibility.* Services as described in rule 441—61.5(217) may be provided in the first 60 months of resettlement unless the Office of Refugee Resettlement grants an exception to the 60-month limit. Referral, interpretation, citizenship, and naturalization services may be provided to the extent feasible past 60 months of resettlement for refugees, except that refugees who are receiving employability services, as defined in 441—subrule 61.5(11), as part of an employability plan, as of September 30, 1995, may continue to receive those services through September 30, 1996, or until the services are completed, whichever occurs first, regardless of their length of residence in the United States. In any case, services shall first be provided for those refugees who are in the first two years of resettlement and who are in need of assistance in securing self-sufficiency.

61.6(3) *Service requirements.*

a. Services provided shall be refugee-specific services which are designed specifically to meet refugee needs, except that vocational or job skills training, on-the-job training, or English language training need not be refugee specific.

b. Services shall be provided, to the maximum extent feasible, in a manner that is culturally and linguistically compatible with a refugee's language and cultural background.

c. Services shall be provided, to the maximum extent feasible, in a manner that includes the use of bilingual or bicultural women to ensure adequate service access by refugee women.

d. The department shall use its social service grants primarily for employability services designed to enable refugees to obtain jobs within one year of becoming enrolled in services in order to achieve economic self-sufficiency as soon as possible.

e. Social services may continue to be provided after a refugee has entered a job to help the refugee retain employment or move to a better job.

f. Social service grant funds may not be used for long-term training programs such as vocational training that last for more than a year or educational programs that are not intended to lead to employment within a year.

g. In planning and providing services, the bureau shall take into account those services which a resettlement agency is required to provide for a refugee whom it sponsors in order to ensure the provision of seamless, coordinated services to refugees that are not duplicative.

441—61.7(217) Application for services. Any person wishing to do so shall have an opportunity to apply for services by contacting the bureau or any of its affiliated offices either in person, by telephone, by fax, in writing, or by contacting any of the bureau staff members. The bureau shall determine the eligibility of each person for services. Applicants for refugee cash assistance shall automatically be considered as applicants for services. The bureau shall ensure that refugee women have the same opportunities as refugee men to participate in all services, including job placement services.

441—61.8(217) Adverse service actions.

61.8(1) *Denial.* Services shall be denied when it is determined by the department that any of the following reasons apply:

a. The client is not in need of the service.

b. The client is not legally eligible.

c. The service is not covered in the state refugee program plan.

d. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.

e. The service for which the client is eligible is currently not available. A list of these services will be posted in the bureau's offices.

f. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in the bureau offices.

g. The client refuses to allow documentation of eligibility.

h. The services requested are those for which other resettlement agencies are contractually responsible.

i. The person requesting service has been in the United States more than 60 months and the services requested do not include referral, interpretation, citizenship, or naturalization services.

61.8(2) *Termination.* A particular service may be terminated when the department determines that any of the following reasons apply:

a. The need to attain the goals to which the service was directed has been achieved.

b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain goals set forth in the individual employability plan.

c. After repeated efforts, it is evident that the client is unwilling to accept further service.

d. The service is no longer available in the Iowa state refugee program plan.

e. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.

f. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in the bureau's offices.

g. The person receiving service has been in the United States more than 60 months and the services the person is receiving do not include referral or interpretation services.

61.8(3) *Reduction.* A particular service may be reduced when the department determines that any of the following reasons apply:

a. Continued provision of service at its current level is not necessary. The department shall determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.

b. Another community resource is available to provide the same or similar service to the client, at no financial cost to the client, that will meet the client's need.

c. Funding is not available to continue the service at the current level. The client shall be reassessed to determine the level of service to be provided.

61.8(4) *Notice of adverse action.* In case of an action to terminate, reduce, or deny services, the bureau shall give notice to the person or persons affected.

441—61.9(217) Client appeals. Decisions made by the department or its designee adversely affecting its clients may be appealed according to 441—Chapter 7.

441—61.10(217) Refugee sponsors. The department is required under its resettlement contract with the U.S. Department of State to secure a sponsor for each refugee unit it resettles. Applications for sponsorship through the department are open, but not limited to, Iowans representing: individuals; individuals representing a group, club, organization, or business; and churches or other religious organizations. Refugee sponsors must comply with a formal application process with the department and complete Form 402-0043, Sponsorship Application. The refugee sponsor must be able to provide certain types of nonfinancial assistance to the refugee unit as outlined by the department. The deputy chief of the bureau accepts or rejects each refugee sponsor application.

441—61.11(217) Adverse actions regarding sponsor applications. Applications shall be denied when it is determined by the department that any of the paragraphs or subparagraphs below apply:

61.11(1) The potential sponsor:

a. Seeks to benefit financially by sponsoring a refugee family.

b. Refuses to fill out and sign the Sponsorship Application.

c. Is not economically self-sufficient.

d. Seeks to engage a refugee family in political, economic, religious, or social activities which are intended to restrict the refugees' freedom of choice after they have arrived in Iowa. This includes but is not limited to instances where a potential sponsor seeks to impose the sponsor's beliefs, lifestyle, or efforts for economic gain on the refugee.

e. Refuses to take part in the department's orientation programs for sponsors.

f. Lacks the commitment of time and resources necessary to fulfill the responsibilities of sponsorship as defined in the Sponsorship Application.

g. Performed inadequately as a prior sponsor and failed to fulfill the responsibilities of sponsorship as defined in the Sponsorship Application, Form 402-0043.

h. Has been convicted of an aggravated or serious misdemeanor or felony and that conviction may directly or adversely impact the refugee family or would endanger the family.

61.11(2) The placement of a refugee family with a specific sponsor would cause undue physical or psychological hardship on the newly arrived refugee due to geographic isolation from support services or activities.

441—61.12(217) Administrative review of denial of sponsorship application. Sponsors may request an administrative review when their applications are denied. The request shall be in writing and must be received by the department no later than 30 days after the date of the notification of denial.

61.12(1) When a sponsor wishes a review of a denial, it will be referred to the chief of the bureau. The bureau chief will affirm or reverse the denial within 20 days of the request.

61.12(2) When the bureau chief affirms the denial, the sponsor may request further review by sending a letter requesting review and the bureau chief's denial to the administrator of the division of policy coordination within ten days of the date of the bureau chief's denial. When more information is needed, the administrator shall request the information within five days. The administrator shall review the denial and issue a decision within ten days of the request for the review or the receipt of additional information, whichever is later.

441—61.13(217) Refugee resettlement moneys. The department receives a certain amount of money from the U.S. Department of State for each refugee it resettles. A portion of that money is made available to the refugee sponsor for financial assistance in resettling the refugee unit. All of the moneys must be spent in accordance with financial requirements and approved expenditures of the department, U.S. Department of State, and the state of Iowa comptroller and must go toward the benefit of the refugee unit. The sponsor must sign Form 402-0025, Receipt Letter, to document the receipt of all refugee resettlement funds. The refugee sponsor must not financially benefit in any way from the refugee resettlement moneys.

441—61.14(217) Unaccompanied refugee minors program. The department administers the unaccompanied refugee minors program under rules covered in 441—Chapters 156, 202, 112, 113, 114, 115, and 116 and by federal guidelines provided by the U.S. Department of Health and Human Services. In consultation with other resettlement agencies, the director determines the number of unaccompanied minors to be resettled in Iowa. Resettlement agencies may not bring unaccompanied minors into Iowa without the authorization of the director.

441—61.15(217,622A) Interpreters and translators for legal proceedings. The languages offered by the bureau for interpretation and translation services shall be Serbo-Croatian, Nuer, Cambodian, Hmong, Laotian, Vietnamese, and Tai Dam. Documents to be translated shall be limited to those specified by the presiding judicial officer as those requiring translation and may be any written materials including offers of evidence, correspondence, briefs, memoranda, or other documents. A certification will be attached to each document that certifies that the translator is competent to translate and that the translation is accurate.

61.15(1) *Requests for interpretation or translation services.* A presiding judicial officer shall initiate the request for interpretation or translation services if the officer determines on the officer's own motion or on the motion of a party that the party (including a defendant in a criminal case) or a witness who may present testimony in the action speaks only or primarily a language other than the English language so as to inhibit the party's comprehension of the proceedings or communication with counsel or the presiding judicial officer or so as to inhibit a witness's comprehension of questions and the presentation of testimony.

61.15(2) *Method of interpretation.* The method of interpretation to be used by staff interpreters will be the consecutive mode, except when the presiding judicial officer authorizes, with the approval of all interested parties, that a summary interpretation will aid in the efficient administration of justice.

61.15(3) *Qualifications and assignment of staff.* Interpreters and translators must be capable of interpreting or translating precisely from a language other than English to English and from English to a language other than English. The bureau chief shall maintain a current master list of all staff interpreters and translators determined as qualified.

The bureau chief or designee shall assign interpreters or translators to each request for services, after consultation with the presiding judicial officer of the court.

61.15(4) *Roles and responsibilities of interpreters and translators.* Staff interpreters and translators shall provide interpretation and translation services during business hours Monday through Friday (8

a.m. to 4:30 p.m.) and occasionally beyond those hours of operation, if required. The interpreter or translator shall:

a. Keep all assignment-related information strictly confidential.

b. Not counsel, elaborate, advise or interject personal opinions.

c. Function in a professional manner appropriate for the situation.

d. Interpret in the method prescribed by the presiding judicial officer and limited to the methods described in this rule.

e. Maintain a solid perspective on the role of the interpreter or translator (the main function is solely a linguistic one to facilitate communication).

f. Not be responsible for what is said, only for conveying it accurately.

g. Withdraw from assignments if the interpreter's or translator's own feelings or beliefs will interfere with rendering the message accurately.

h. Withdraw from assignments where family members or close personal or professional relationships may affect impartiality.

i. Swear or affirm to interpret or translate accurately.

61.15(5) *Dismissal or disqualification of interpreter.* If any interpreter is unable to communicate effectively with the presiding judicial officer, the attorney, a party (including a defendant in a criminal case), or a witness, the presiding judicial officer may dismiss the interpreter and obtain the services of another interpreter.

Any court or administrative agency may inquire into the qualifications and integrity of any interpreter and may disqualify any person from serving as an interpreter.

61.15(6) *Fee schedule.* The bureau shall not be compensated for costs related to interpretation or translation services in excess of the maximum allowable under the schedule of fees prescribed pursuant to this subrule. Any moneys collected under this rule shall be used to reimburse the appropriation obligated and disbursed in payment for services.

a. Rate for services. The fee schedule for interpretation services shall be based on a portal-to-portal basis multiplied by the appropriate rate. The standard rate shall be $25 per hour, plus actual expenses not to exceed the state reimbursement rate for meals, lodging, parking, and ground or air transportation costs incurred in providing services.

When a single interpretation assignment exceeds six hours, a flat salary rate of $150 per day, plus actual expenses, not to exceed the state reimbursement rate, shall be charged.

The fee for translating documents shall be $25 per page for verbatim translations and $10 per page for summary translations.

b. Minimum charges. A minimum charge of one hour shall be charged for providing requested interpretation services. A minimum of one hour shall be charged for cancellations less than 12 hours prior to a prescheduled appointment. A minimum one-hour charge, plus incidental costs, shall be charged for party no-shows.

For any legal action preparatory to appearing before any court which is facilitated through a telephone interpretation, a minimum charge of 15 minutes shall be charged. A charge for each additional 15-minute increment, after the first 15 minutes, shall be billed at a prorated share of the scheduled standard rate of $25 per hour.

61.15(7) *Payment.* Payment for interpretation and translation services invoiced according to the fee schedule shall be issued to the bureau by the clerk of court, if the interpreter or translator is appointed by the presiding judicial officer, unless other state or federal statutory provisions preclude the payment. The presiding judicial officer may order that all or part of the salaries, fees, expenses and costs be apportioned between or among the parties or be taxed according to existing state or federal statutory provisions.

Invoices for interpretation and translation services shall be sent on the tenth of the month following the service date to the appropriate clerk of court. Information on this invoice form is considered confidential and shall include:

1. Name and address of party initiating the service request.
2. Date, time and location of assignment.
3. Description and rate.

4. Hours of service delivery.
5. Name of interpreter(s) and translator(s).
6. Detailed statement of related costs.

441—61.16(217) Pilot recredentialing services. The department shall make available, as a pilot program, recredentialing services for refugees who are graduates of a foreign school that qualifies its students for certification or licensure as registered nurses or licensed practical nurses. These pilot services shall be available to the extent that funding is available through the federal fiscal year 2001 Polk County targeted assistance grant (see 441—61.17(217) for definition) and through Office of Refugee Resettlement social services funds up to a maximum of $22,500. The pilot program shall end September 30, 2003.

61.16(1) *Services included in recredentialing services.* In addition to employability services as described in subrule 61.5(11), the department shall provide the following to participants in recredentialing services:

a. Practical assistance in securing documents and services needed to achieve evaluation of credentials earned outside the United States through appropriate United States professional credentials-evaluation organizations.

b. Payment of the initial fee for services of professional credentials-evaluation organizations.

c. Payment, to a maximum of $5,000 per eligible refugee, as contracted for or otherwise arranged or approved by the bureau, for professional refresher training or other education or training services to enable participants to achieve Iowa certification or licensure.

61.16(2) *Limitations on recredentialing services.* In addition to the policies described in rule 441—61.6(217), the following shall apply to participants in recredentialing services:

a. The department shall identify eligible participants for recredentialing services through the appropriate employability assessment services as provided in paragraph 61.5(11)*"b."*

b. The department shall deny eligibility for recredentialing services when the applicant cannot achieve acceptable levels in bureau-administered assessment tests of English literacy, spoken English proficiency, and math proficiency.

c. The department shall consider that eligibility for recredentialing services begins with payment of the fee to the appropriate professional credentials-evaluation organization.

d. The department shall deny or terminate eligibility for recredentialing services when it becomes clear that recredentialing cannot be achieved within the limitations as provided in rule 441—61.6(217). In addition to the appropriate professional credentials-evaluation organization, appropriate education and training institutions may be consulted to determine whether recredentialing may be achieved within these limitations.

e. The department shall limit eligibility for recredentialing services based on place of residence only so far as the source of recredentialing services funding requires such limitation.

441—61.17(217) Targeted assistance grants. "Targeted assistance grants" means U.S. Department of Health and Human Services formula allocation funding granted to the department for assistance to counties where, because of factors such as unusually large refugee populations (including secondary migration), high refugee concentrations, and high use of public assistance by refugees, there exists and can be demonstrated a specific need for supplementation of available resources for services to refugees.

61.17(1) *Administration of targeted assistance grants.* The department shall make 95 percent of the total award available to the designated county except when the designated county has agreed to let the department administer the targeted assistance grant in its stead.

61.17(2) *Eligibility for services under targeted assistance grants.* Services funded by targeted assistance grants are limited to refugees who reside in the designated county.

61.17(3) *Services and limitations for services funded by targeted assistance grants.* Rules of 441—Chapter 61 are applicable to services funded by targeted assistance grants, except for subrules 61.5(5) and 61.6(1).

61.17(4) *Priority of services.* Services funded by targeted assistance grants shall be provided in the following order of priority, except in certain individual extreme circumstances:

1. Cash assistance recipients, particularly long-term recipients.
2. Unemployed refugees who are not receiving cash assistance.
3. Employed refugees in need of services to retain employment or to attain economic independence.

441—61.18(217) Iowa refugee services foundation. An Iowa refugee services foundation is established to engage in refugee resettlement activities to promote the welfare and self-sufficiency of refugees who live in Iowa and are not citizens of the United States. The structure and authority of the foundation shall be as prescribed in Iowa Code section 217.41 and in the bylaws adopted by the board of directors.

61.18(1) *Board of directors.* The foundation board of directors shall perform the duties and functions necessary and proper to carry out the foundation's responsibilities.

a. *Composition.* The board shall consist of five members, one appointed by the governor and four appointed by the director of the department of human services.

b. *Term.* Members of the board shall be appointed to three-year terms, except as described in paragraph *"c."* Terms shall begin on July 1 and end on June 30.

c. *Initial term.* The initial term of the members appointed by the director of the department of human services shall be as follows:

(1) One member appointed for three years.
(2) Two members appointed for two years.
(3) One member appointed for one year.

d. *Equity.* Not more than two members appointed by the director of the department of human services shall be of the same gender or of the same political party.

e. *Vacancy.* A vacancy on the board shall be filled in the same manner as the original appointment for the remainder of the term.

61.18(2) *Board meetings.* The board of directors shall meet at least once each year to elect one of its members as chairperson.

These rules are intended to implement Iowa Code sections 217.6 and 217.41 and chapter 622A.

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CHAPTERS 62 and 63
Reserved

CHAPTER 64
RELIEF FOR NEEDY INDIANS
Rescinded IAB 9/1/93, effective 11/1/93

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

[Prior to 7/1/83, Social Services[770] Ch 65]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The basis for the food assistance program is as provided in Title 7 of the Code of Federal Regulations. The purpose of this chapter is to provide for adoption of new and amended federal regulations as they are published, to establish a legal basis for Iowa's choice of administrative options when administrative options are given to the state in federal regulations, to implement the policy changes that the United States Department of Agriculture (USDA) directs states to implement that are required by law but are not yet included in federal regulations, and to implement USDA-approved demonstration projects and waivers of federal regulations.

DIVISION I

441—65.1(234) Definitions.

"Department" means the Iowa department of human services.

"Food assistance" means benefits provided by the federal program administered through Title 7, Chapter II of the Code of Federal Regulations, Parts 270 through 283.

"Notice of expiration" means either a message printed on an application for continued program participation, Review/Recertification Eligibility Document (RRED), Form 470-2881, which is automatically issued to the household, or a hand-issued Form 470-0325, Notice of Expiration.

"Parent" means natural, legal, or stepmother or stepfather.

"Sibling" means biological, legal, step- , half- , or adoptive brother or sister.

441—65.2(234) Application.

65.2(1) *Application filing.* Persons in need of food assistance benefits may file an application at any local department office in Iowa or over the Internet.

a. An application is filed the day a local department office receives an application for food assistance benefits that contains the applicant's name and address and is signed by either a responsible member of the household or the household's authorized representative. The application may be filed on:

(1) Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance;

(2) Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application; or

(3) Form 470-4080 or 470-4080(S), Electronic Food Assistance Application.

b. 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. An electronic application is considered received on the first department workday following the date the department office received the application.

c. A household shall complete a Health and Financial Support Application when any person in the household is applying for or receiving aid through the family investment program, family medical assistance program (FMAP)-related Medicaid, or the refugee resettlement assistance programs.

d. The application is complete when a completed application form is submitted.

e. Households receiving food assistance benefits in Iowa may apply for continued participation by submitting Form 470-2881, Review/Recertification Eligibility Document.

65.2(2) *Failure to provide verification.* When a household files an initial application and the department requests additional verification, the applicant shall have ten days to provide the requested verification. If the applicant fails to provide the verification within ten days, the department may deny the application immediately. If the applicant provides the department with the requested verification prior to the thirtieth day from the date of application, the department shall reopen the case and provide benefits from the date of application. If the household provides the verification in the second 30 days

after the date of the application, the department shall reopen the case and provide benefits from the date the verification was provided.

441—65.3(234) Administration of program. The food assistance program shall be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq., and in accordance with federal regulation, Title 7, Parts 270 through 283 as amended to June 19, 2006. A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the Division of Financial, Health, and Work Supports, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, (515)281-3133.

441—65.4(234) Issuance. The department shall issue food assistance benefits by electronic benefits transfer (EBT).

65.4(1) *Schedule.* Benefits for ongoing certifications shall be made available to households on a staggered basis during the first ten calendar days of each month.

65.4(2) *EBT cards.* EBT cards shall be mailed to clients.

a. Personal identification number selection. When a client receives the EBT card, the client shall call the automated response unit to select a personal identification number. The client must provide proof of identity before selecting the personal identification number.

b. Replacement of EBT cards. EBT cards shall be replaced within five business days after the client notifies the EBT customer service help desk of the need for replacement.

65.4(3) *Client training.* Written client training materials may either be mailed to clients or be handed to the clients if they visit the local office. Clients will be given in-person training upon request or if they are identified as having problems using the EBT system.

65.4(4) *Point-of-sale terminals.* Point-of-sale terminals allow clients to access food assistance benefits and retailers to redeem food sales.

a. Redemption threshold. The department will not place point-of-sale terminals with any authorized retailer with less than $100 in monthly food assistance redemptions. Those retailers may participate through a manual voucher process described in paragraph 65.4(5)*"b."*

b. Shipping. Government-supplied point-of-sale terminals may be shipped to authorized retailers along with instructions for installation of the equipment and training materials. A toll-free number is available for retailers needing assistance.

c. Replacement. The department shall ensure that government-supplied point-of-sale terminals that are not operating properly are repaired or replaced within 48 hours.

65.4(5) *Voucher processing.*

a. Emergency vouchers. Authorized retailers may use an emergency manual voucher if they cannot access the EBT host system.

(1) The client shall sign Form 470-2827, POS Voucher, to authorize a debit of the household's EBT account.

(2) The retailer shall clear the manual transaction as soon as the host system becomes operational.

(3) The retailer shall receive a payment of the actual amount of the voucher, up to a maximum of $50.

b. Manual vouchers. Authorized retailers without point-of-sale terminals and retailers whose equipment fails may use a manual voucher. If a manual voucher is used:

(1) The client shall sign Form 470-3980, Offline Food Stamp Voucher: Non Equipped Retailer (No POS), to authorize a debit of the household's EBT account.

(2) The retailer shall obtain a telephone authorization from the EBT retailer help desk before finalizing the purchase.

(3) The retailer shall clear the manual transaction within 30 days.

(4) If there are insufficient funds in the client's account when the voucher is presented, the client's account shall be debited for the amount in the account. The remainder of the amount owed shall be

deducted from benefits issued for subsequent months. If the next month's allotment is less than $50, the deduction shall not exceed $10.
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.5(234) Simplified reporting.

65.5(1) *Identification.* All households are subject to simplified reporting requirements.

65.5(2) *Determination of eligibility and benefits.* Eligibility and benefits for simplified reporting households shall be determined on the basis of the household's prospective income and circumstances.

65.5(3) *Certification periods.* Households shall be certified as follows:

a. Households that have no earned income and in which all adult members are elderly or disabled shall be assigned certification periods of 12 months.

b. All other households shall be assigned certification periods of six months.

c. Exceptions:

(1) A household that has unstable circumstances or that includes an able-bodied adult without dependents shall be assigned a shorter certification period consistent with the household's circumstances, but generally no less than three months.

(2) A shorter certification period may be assigned at application or recertification to match the food assistance recertification date to the family investment program or medical assistance annual review date.

65.5(4) *Reporting responsibilities.* Simplified reporting households are required to report changes as follows:

a. The household shall report if the household's total gross income exceeds 130 percent of the federal poverty level for the household size. The household must report this change within ten days of the end of the month in which the income exceeds this level. A categorically eligible household that reports income over 130 percent of the federal poverty level and that remains eligible for benefits shall not be required to make any additional report of changes.

b. A household containing an able-bodied adult without dependents shall report any change in work hours that brings that adult below 20 hours of work per week, averaged monthly. The household must report this change within ten days of the end of the month in which the change in work hours occurs.

65.5(5) *Verification submitted with report form.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(6) *Additional information and verification.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(7) *Action on reported changes.* The department shall act on all reported changes for households regardless of the household's reporting requirements.

65.5(8) *Entering or leaving simplified reporting.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(9) *Reinstatement.* Rescinded IAB 9/10/08, effective 10/1/08.

441—65.6(234) Delays in certification.

65.6(1) When by the thirtieth day after the date of application the agency cannot take any further action on the application due to the fault of the household, the agency shall give the household an additional 30 days to take the required action. The agency shall send the household a notice of pending status on the thirtieth day.

65.6(2) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is complete enough to determine eligibility, the application shall be processed. For subsequent months of certification, the agency may require a new application form to be completed when household circumstance indicates changes have occurred or will occur.

65.6(3) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is not complete enough to determine eligibility, the application shall be denied. The household shall be notified to file a new application and that it may be entitled to retroactive benefits.

441—65.7(234) Expedited service. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.8(234) Deductions.

65.8(1) *Standard allowance for households with heating or air-conditioning expenses.* When a household is receiving heating or air-conditioning service for which it is required to pay all or part of

the expense or receives assistance under the Low-Income Home Energy Assistance Act (LIHEAA) of 1981, the heating or air-conditioning standard shall be allowed.

a. The standard allowance for utilities which include heating or air-conditioning costs shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

b. Effective October 1, 2013, five dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction.

65.8(2) *Heating expense.* Heating expense is the cost of fuel for the primary heating service normally used by the household.

65.8(3) *Telephone standard.* When a household is receiving a standard utility allowance under subrule 65.8(1) or 65.8(5) or is solely responsible for telephone expenses, a standard allowance shall be allowed. This allowance shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

65.8(4) *Energy assistance payments.* For purposes of prorating the low income energy assistance payments to determine if households have incurred out-of-pocket expenses for utilities, the heating period shall consist of the months from October through March.

65.8(5) *Standard allowance for households without heating or air-conditioning expenses.* When a household is receiving some utility service other than heating or air-conditioning for which it is responsible to pay all or part of the expense, the nonheating or air-conditioning standard shall be allowed. These utility expenses cannot be solely for telephone.

a. This allowance shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

b. Effective October 1, 2013, five dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction.

65.8(6) *Excluded payments.* A utility expense which is reimbursed or paid by an excluded payment, including HUD or FmHA utility reimbursements, shall not be deductible.

65.8(7) *Excess medical expense deduction.* Notwithstanding anything to the contrary in these rules or regulations, at certification, households having a member eligible for the excess medical expense deduction shall be allowed to provide verification of expenses so that a reasonable projection of the member's medical expenses anticipated to occur during the household's certification period can be made. The household may choose to claim actual expenses or to use the standard medical expense deduction.

a. *Actual medical expense.*

(1) The projection may be based on available information about the member's medical condition, public or private medical insurance coverage, and current verified medical expenses.

(2) Households that choose to claim actual medical expenses shall not be required to report changes in medical expenses that were anticipated to occur during the certification period.

b. *Standard medical expense.*

(1) A household may choose a standard medical expense deduction of $105 if the household incurs more than $35 per month in medical expenses.

(2) A household that chooses the standard deduction shall not be required to report changes in medical expenses during the certification period.

c. Rescinded IAB 8/1/07, effective 10/1/07.

65.8(8) *Child support payment deduction.* Rescinded IAB 5/2/01, effective 6/1/01.

65.8(9) *Standard deduction.* Each household will receive a standard deduction from income equal to 8.31 percent of the net income limit for food assistance eligibility. No household will receive an amount less than $144 or more than 8.31 percent of the net income limit for a household of six members. The amount of the standard deduction is adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.8(10) *Sharing utility standards.* Rescinded IAB 9/4/02, effective 10/1/02.

65.8(11) *Excess shelter cap.* Rescinded IAB 5/2/01, effective 6/1/01.

This rule is intended to implement Iowa Code section 234.12.

[**ARC 8992B**, IAB 8/11/10, effective 10/1/10; **ARC 1148C**, IAB 10/30/13, effective 1/1/14]

441—65.9(234) Treatment centers and group living arrangements. Alcohol or drug treatment or rehabilitation centers and group living arrangements shall complete Form 470-2724, Monthly Facility Report, on a monthly basis and return the form to the local department office where the center is assigned.

441—65.10(234) Reporting changes. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.11(234) Discrimination complaint. Individuals who feel that they have been subject to discrimination may file a written complaint with the Diversity Programs Unit, Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

441—65.12(234) Appeals. Fair hearings and appeals are provided according to the department's rules, 441—Chapter 7.

441—65.13(234) Joint processing.

65.13(1) *Joint processing with SSI.* The department will handle joint processing of supplemental security income and food assistance applications by having the social security administration complete and forward food assistance applications.

65.13(2) *Joint processing with public assistance.* The department shall jointly process public assistance and food assistance applications.

65.13(3) *Single interview for assistance.* In joint processing of public assistance and food assistance applications, the department shall conduct a single interview at initial application for both purposes.

441—65.14(234) Rescinded, effective 10/1/83.

441—65.15(234) Proration of benefits. Benefits shall be prorated using a 30-day month.

This rule is intended to implement Iowa Code section 234.12.

441—65.16(234) Complaint system. Clients wishing to file a formal written complaint concerning the food assistance program may submit Form 470-0323, or 470–0323(S), Food Assistance Complaint, to the office of field support. Department staff shall encourage clients to use the form.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.17(234) Involvement in a strike. An individual is not involved in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The service area manager shall determine whether such a risk to the individual's physical or emotional well-being exists.

441—65.18(234) Rescinded, effective 8/1/86.

441—65.19(234) Monthly reporting/retrospective budgeting. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.20(234) Notice of expiration issuance.

65.20(1) Issuance of the automated Notice of Expiration will occur with the mailing of Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), or a hand-issued Form 470-0325, Notice of Expiration.

65.20(2) Issuance of the Notice of Expiration, Form 470-0325, will occur at the time of certification if the household is certified for one month, or for two months, and will not receive the automated Notice of Expiration.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.21(234) Claims.

65.21(1) *Time period.* Inadvertent household error claims shall be calculated back to the month the error originally occurred to a maximum of three years before the month of discovery of the overissuance. Agency error claims shall be calculated back to the month the error originally occurred to a maximum of one year before the month of discovery of the overissuance.

65.21(2) *Suspension status.* Rescinded IAB 7/1/98, effective 8/5/98.

65.21(3) *Application of restoration of lost benefits.* Rescinded IAB 3/6/02, effective 5/1/02.

65.21(4) *Demand letters.* Households that have food assistance claims shall return the repayment agreement no later than 20 days after the date the demand letter is mailed.

a. For agency error and inadvertent household error, when households do not return the repayment agreement by the due date or do not timely request an appeal, allotment reduction shall occur with the first allotment issued after the expiration of the Notice of Adverse Action time period.

b. For intentional program violation, when households do not return the repayment agreement by the due date, allotment reduction shall occur with the next month's allotment.

65.21(5) *Adjustments for claim repayment.* A household or authorized representative may initiate a claim repayment by using benefits in an EBT account. The client or authorized representative shall complete Form 470-2574, EBT Adjustment Request, to authorize adjustments to a household's EBT account.

65.21(6) *Collection of claims.* Rescinded IAB 5/30/01, effective 8/1/01.

[**ARC 7928B**, IAB 7/1/09, effective 9/1/09]

441—65.22(234) Verification.

65.22(1) *Required verification.*

a. *Income.* Households shall be required to verify income at time of application, recertification and when income is reported or when income changes with the following exceptions:

1. Households are not required to verify the public assistance grant.

2. Households are not required to verify job insurance benefits when the information is available to the department from the department of employment services.

3. Households are only required to verify interest income at the time of application and recertification.

b. *Dependent care costs.* Rescinded IAB 3/10/10, effective 2/10/10.

c. *Medical expenses.* Households shall be required to verify medical expenses at the time of application and whenever a change is reported. For recertification:

(1) A household that chose to claim actual expenses must verify medical expenses.

(2) A household that chose the standard medical expense deduction shall be required to declare only if the excess expense still exists.

d. *Shelter costs.* Rescinded IAB 3/10/10, effective 2/10/10.

e. *Utilities.* Rescinded IAB 3/10/10, effective 2/10/10.

f. *Telephone expense.* Rescinded IAB 5/2/01, effective 6/1/01.

g. *Child support payment deduction.* Households shall be required to verify legally obligated child support and child medical support payments made to a person outside of the food assistance household only at certification and recertification and whenever the household reports a change.

65.22(2) *Failure to verify.* When the household does not verify an expense as required, no deduction for that expense will be allowed.

65.22(3) *Special verification procedures.* Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a second face-to-face interview and additional documentation requirements in accordance with department of inspections and appeals' rules 481—Chapter 72.

Clients are required to cooperate with the investigation division of the department of inspections and appeals in establishing eligibility factors, including attending requested interviews. Refusal to cooperate will result in denial or cancellation of the household's food assistance benefits. Once denied or terminated

for refusal to cooperate, the household may reapply but shall not be determined eligible until cooperation occurs.
[**ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—65.23(234) Prospective budgeting.

65.23(1) *Weekly or biweekly income.* The department shall convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program procedures.

65.23(2) *Income averaging.* The department shall average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

441—65.24(234) Inclusion of foster children in household. Foster children living with foster parents will not be considered to be members of the food assistance household unless the household elects to include the foster children in the household. Foster care payments received for foster children not included in the household will be excluded from the income of the household receiving the payment.

441—65.25(234) Effective date of change. A food assistance change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

441—65.26(234) Eligible students. A student who is enrolled in an institution of higher education shall meet student eligibility criteria if the student:

1. Is employed for an average of 20 hours per week and is paid for this employment; or
2. Is self-employed for an average of 20 hours per week and receives average weekly earnings at least equal to the federal minimum wage multiplied by 20 hours.

441—65.27(234) Voluntary quit or reduction in hours of work.

65.27(1) *Applicant households.* A member of an applicant household who without good cause voluntarily quits a job or reduces hours of work to less than 30 hours weekly within 30 days before the date the household applies for benefits shall be disqualified from participating in the food assistance program according to the provisions of paragraphs 65.28(12)*"a"* and *"b."*

65.27(2) *Participating individuals.* Participating individuals are subject to the same disqualification periods as provided under subrule 65.28(12) when the participating individuals voluntarily quit employment without good cause or voluntarily reduce hours of work to less than 30 hours per week, beginning with the month following the adverse notice period.

441—65.28(234) Work requirements.

65.28(1) *Persons required to register.* Each household member who is not exempt by subrule 65.28(2) shall be registered for employment at the time of application, and once every 12 months after initial registration, as a condition of eligibility. Registration is accomplished when the applicant signs an application form that contains a statement that all members in the household who are required to register for work are willing to register for work. This signature registers all members of that food assistance household that are required to register.

65.28(2) *Exemptions from work registration.* The following persons are exempt from the work registration requirement:

a. A person younger than 16 years of age or a person 60 years of age or older. A person aged 16 or 17 who is not a head of a household or who is attending school, or is enrolled in an employment training program on at least a half-time basis is exempt.

b. A person physically or mentally unfit for employment.

c. A household member subject to and complying with any work requirement under Title IV of the Social Security Act including mandatory PROMISE JOBS referral.

d. A parent or other household member who is responsible for the care of a dependent child under age six or an incapacitated person.

e. A person receiving unemployment compensation.

f. A regular participant in a drug addiction or alcohol treatment and rehabilitation program which is certified by the Iowa department of public health, division of substance abuse.

g. A person who is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

h. A student enrolled at least half-time in any recognized school, recognized training program, or an institution of higher education (provided that students have met the requirements of federal regulation, Title 7, Part 273.5, as amended to December 31, 1986).

65.28(3) *Losing exempt status.* Persons who lose exempt status due to any change in circumstances that is subject to the reporting requirements shall register for employment when the change is reported. Persons who lose exempt status due to a change in circumstances that is not subject to the reporting requirements for that household shall register for employment no later than at the household's next recertification.

65.28(4) *Registration process.* Upon reaching a determination that an applicant or a member of the applicant's household is required to register, the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failure to comply shall be explained to the applicant. A written statement of the above shall be provided to each registrant in the household. The written statement shall also be provided at recertification and when a previously exempt member or a new household member becomes subject to work registration.

Registration for all nonexempt household members required to work register is accomplished when the applicant or recipient signs an application, recertification, or reporting form containing an affirmative response to the question, "Do all members who are required to work register and participate in job search agree to do so?" or similarly worded statement.

65.28(5) *Deregistration.* Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.28(6) *Work registrant requirements.* Work registrants shall respond to a request from the department or its designee for supplemental information regarding employment status or availability for work.

65.28(7) *Employment and training program.*

a. The employment and training program for food assistance recipients is designed to assist:

(1) Persons who have lost jobs or are underemployed and who need new skills in order to reenter the workplace because there are no jobs available for which the persons are trained.

(2) Persons who have been out of the workforce for a period of time to regain licensure or certification in an area in which they are already trained.

(3) Persons who wish to upgrade their employment for better wages and benefits.

b. The department or its designee shall serve as the provider of employment and training services for food assistance recipients who wish to volunteer, except for those who are also recipients of family investment program (FIP) benefits. Federal law prohibits FIP recipients from participating in any food assistance employment and training program.

c. The program offers a range of services from basic skills to advanced training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a volunteer to engage in vocational testing activities when deemed necessary to determine if a component is appropriate for improving the volunteer's opportunity for employment.

65.28(8) *Employment and training components.* Employment and training components include individual job search, job club, educational services, and job retention services. The department or its designee shall offer employment and training components subject to the availability of sufficient funding to cover program costs. Availability of components may vary among the areas where employment and training are offered.

a. *Individual job search.* The individual job search shall be modeled after the family investment program's PROMISE JOBS individual job search component, as described at 441—subrule 93.6(2).

b. *Job club.* The employment and training job club shall be modeled after the family investment program's PROMISE JOBS job club, as described at 441—subrule 93.6(1).

c. Educational services. Educational services offered shall include general educational development (GED), adult basic education (ABE), English as a second language (ESL), and vocational training or educational opportunities limited to a two-year college degree. Educational services may include, but are not limited to, obtaining continuing education credit hours needed for a recipient to become recertified or to renew licensure for a profession.

d. Job retention services. Job retention services are intended to provide needed assistance with costs associated with beginning employment. Services are available only to persons who have received employment or training services under this subrule. Job retention services will be offered up to 90 days after the person secures employment. Services may include payment of:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) The cost of testing, certification, licensing, bonding, or legal services required for employment.

(3) The cost of equipment, tools, uniforms, or other special clothing required by the job.

(4) Other reasonable and necessary costs related to starting and retaining employment.

65.28(9) *Exemptions from employment and training programs.* Rescinded IAB 5/5/10, effective 4/15/10.

65.28(10) *Time spent in an employment and training program.* Rescinded IAB 5/5/10, effective 4/15/10.

65.28(11) *Supportive services.* Program participants shall be provided with services necessary to complete an employment and training component to the extent allowable under federal regulations at 7 CFR 237.7(e)(4) as amended to January 1, 2009, and to the extent there is sufficient funding to cover the costs.

a. The department shall provide participants in employment and training components an allowance for costs of transportation or other costs reasonably necessary and directly related to participation in the components as follows:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) Reasonable and necessary costs of attending a specific course of study, such as tuition, books, fees, training manuals, tools, equipment, uniforms and special clothing, safety items, and other items that all students in the course are required to have.

b. The department may authorize the employment and training service provider to reimburse the provider of care directly for the costs of dependent care expenses that the employment and training service provider determines to be necessary for the participation of a person in the components.

(1) Reimbursement for dependent care shall be authorized only to the extent that another source is not available to provide the care at no cost to the employment and training program and shall be based on the child care assistance program reimbursement rates as described at 441—paragraph 170.4(7)*"a."*

(2) The caretaker relative of a dependent in a family receiving FIP is not eligible for the dependent care reimbursement.

65.28(12) *Failure to comply.* This subrule applies only to persons who are mandatory work registrants as required by subrule 65.28(1).

a. When a person has refused or failed without good cause to comply with the work registration requirements in this rule, that person shall be ineligible to participate in the food assistance program as follows:

(1) First violation: The later of (1) the date the individual complies with the requirement; or (2) two months.

(2) Second violation: The later of (1) the date the individual complies with the requirement; or (2) three months.

(3) Third and subsequent violations: The later of (1) the date the individual complies with the requirement; or (2) six months.

b. The disqualification period shall begin with the first month following the expiration of the adverse notice period, unless a fair hearing is requested.

65.28(13) *Noncompliance with comparable requirements.* The department shall treat a mandatory work registrant's failure to comply with an unemployment compensation requirement that is comparable to a food assistance work registration requirement as a failure to comply with the corresponding food assistance requirement. Disqualification procedures in subrule 65.28(12) shall be followed.

65.28(14) *Ending disqualification.* Following the end of the disqualification periods for noncompliance and as provided in rules 441—65.27(234) and 441—65.28(234), participation may resume.

a. An applicant disqualified under subrule 65.27(1) may be approved for benefits after serving the minimum disqualification period and complying with the work requirement, as follows:

(1) If the applicant voluntarily quit a job, the applicant must obtain a job comparable to the one that the applicant quit.

(2) If the applicant voluntarily reduced hours of employment to less than 30 hours per week, the applicant must start working 30 or more hours per week.

b. A disqualified individual who is a member of a currently participating eligible household shall be added to the household after the minimum disqualification period has been served and the person has complied with the failed requirement as follows:

(1) If the member failed or refused to register for work with the department, the member complies by registering.

(2) If the member voluntarily quit a job, the member must obtain a job comparable to the one quit.

(3) If the member voluntarily reduced hours of employment to less than 30 hours per week, the member must start working 30 or more hours per week.

c. An individual may reestablish eligibility during a disqualification period by becoming exempt from the work requirement as provided in subrule 65.28(2).

65.28(15) *Suitable employment.* Employment shall be considered unsuitable if:

a. The wage offered is less than the highest of the applicable federal minimum wage, the applicable state minimum wage, or 80 percent of the federal minimum wage if neither the federal nor state minimum wage is applicable.

b. The employment offered is on a piece-rate basis and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wages specified in paragraph *"a"* above.

c. The household member, as a condition of employment or continuing employment, is required to join, resign from, or refrain from joining a legitimate labor organization.

d. The work offered is at a site subject to a strike or lockout at the time of the offer 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).

e. The household member involved can demonstrate or the department otherwise becomes aware that:

(1) The degree of risk to health and safety is unreasonable.

(2) The member is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

(3) The employment offered within the first 30 days of registration is not in the member's major field of experience.

(4) The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two hours per day, not including the transporting of a child to and from a child care facility. Employment shall also not be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.

(5) The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.

65.28(16) *Applicants for supplemental security income (SSI) and food assistance.* Household members who are jointly applying for SSI and for food assistance shall have the requirements for work registration waived until:

a. They are determined eligible for SSI and thereby become exempt from work registration, or

b. They are determined ineligible for SSI whereupon a determination of work registration status will be made.

65.28(17) *Determining good cause.* The department or its designee shall determine whether good cause exists for failure to comply with the work registration, employment and training, and voluntary quit requirements in 441—Chapter 65. In determining whether good cause exists, the facts and circumstances shall be considered, including information submitted by the household member involved and the employer.

Good cause shall include circumstances beyond the member's control, such as, but not limited to, illness of the registrant or of another household member requiring the presence of the registrant, a household emergency, the unavailability of transportation, or the lack of adequate child care for children who have reached age 6 but are under age 12.

65.28(18) *Measuring the three-year period for able-bodied nonexempt adults without dependents.* The three-year period as provided for in federal regulations at 7 CFR 273.24 as amended to June 19, 2002, starts on December 1, 2002, and ends November 30, 2005. Subsequent three-year periods start with the month of December following the end of the previous period.

65.28(19) *Mini-simplified food assistance program.*

a. *Scope.* The department operates a mini-simplified food assistance program for households that:

(1) Also receive benefits under the family investment program; and

(2) Include a parent who is exempt from food assistance requirements for work registration due to caring for a child under the age of six.

b. *Effect.* The mini-simplified food assistance program allows replacement of certain food assistance program work rules with work rules of the Temporary Assistance to Needy Families program. The value of the household's monthly food assistance benefits shall be combined with the household's monthly family investment program benefit amount to determine the maximum number of hours the department can require a household member under the family investment program to participate in an unpaid work activity that is subject to the federal Fair Labor Standards Act. Maximum required hours of participation for a month are determined by dividing the total amount of benefits by the state or federal minimum wage, whichever wage is higher.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8712B**, IAB 5/5/10, effective 4/15/10]

441—65.29(234) Income.

65.29(1) *Self-employment income.* "Self-employment income" means the net profit from self-employment.

a. *Determination of net profit.* "Net profit from self-employment" means gross self-employment income less:

(1) A standard amount of 40 percent, as allowed by the state's family investment (TANF) program, or

(2) At the household's request, actual allowable expenses as specified in federal regulations at 7 CFR 273.11 as amended to January 1, 2011.

b. *Uneven proration of self-employment income.* Once a household with self-employment income is determined eligible, the household has the following options for computation of the benefit level:

(1) Using the same monthly self-employment income amount which was used to determine eligibility, or

(2) Unevenly prorating the household's annual self-employment income over the period for which the household's self-employment income was averaged to more closely approximate the time when the income is actually received. If this option is chosen, the self-employment income assigned in any month together with other income and deductions at the time of certification cannot result in the household's exceeding the maximum monthly net income eligibility standards for the household's size.

65.29(2) *Job insurance benefits.* When the department of human services uses information provided by the department of workforce development to verify job insurance benefits, the benefits shall be considered received the second day after the date that the check was mailed. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

When the client notifies the agency that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A benefit adjustment shall be made when indicated. The client must report the discrepancy before the benefit month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the benefit month, whichever is later, in order to receive corrected benefits.

65.29(3) *Exclusion of income from 2000 census employment.* Rescinded IAB 9/4/02, effective 10/1/02.

65.29(4) *Interest income.* Prorate interest income by dividing the amount anticipated during the certification period by the number of months in the certification period.

65.29(5) *Social security plans for achieving self-support (PASS).* Notwithstanding anything to the contrary in these rules or regulations, exclude income amounts necessary for fulfillment of a plan for achieving self-support (PASS) under Title XVI of the Social Security Act.

65.29(6) *Student income.* In determining eligibility, the department shall exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

a. Notwithstanding anything to the contrary in these rules or regulations, the department shall exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation and miscellaneous personal expenses (other than living expenses).

b. If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students shall receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

c. For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.29(7) *Elementary and high school student income.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(8) *Vendor payments.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(9) *HUD or FmHA utility reimbursement.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(10) *Welfare reform and regular household honorarium income.* All moneys paid to a food assistance household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

65.29(11) *Income of ineligible aliens.* The department shall use all but a pro-rata share of ineligible aliens' income and deductible expenses to determine eligibility and benefits of any remaining household members.

65.29(12) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to the household.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 0148C**, IAB 6/13/12, effective 8/1/12]

441—65.30(234) Resources.

65.30(1) *Jointly held resources.* When property is jointly held it shall be assumed that each person owns an equal share unless the intent of the persons holding the property can be otherwise established.

65.30(2) *Resource limit.* The resource limit for a household that includes a person aged 60 or over or a disabled person is $3000. The resource limit for other households is $2000. These amounts are adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.30(3) *Resources of SSI and FIP household members.* Notwithstanding anything to the contrary in these rules or in federal regulations, all resources of SSI or FIP recipients are excluded. For food assistance purposes, those members' resources, if identified, cannot be included when a household's total resources are calculated.

65.30(4) *Earned income tax credits.* Notwithstanding anything to the contrary in these rules or in federal regulations, earned income tax credits (EITC) shall be excluded from consideration as a resource for 12 months from the date of receipt if:

a. The person receiving the EITC was participating in the food assistance program at the time the credits were received; and

b. The person participated in the program continuously during the 12-month period.

65.30(5) *Student income.* Exclude from resources any income excluded by subrule 65.29(6).

65.30(6) *Motor vehicles.* One motor vehicle per household shall be excluded without regard to its value. The value of remaining motor vehicles shall be determined using federal regulations at 7 CFR 273.8, as amended to April 29, 2003.

65.30(7) *Retirement accounts.* Exclude from resources the value of:

a. Any funds in a plan, contract, or account described in Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c)(18) of the Internal Revenue Code of 1986.

b. Any funds in a Federal Thrift Savings Plan account as provided in Section 8439 of Title 5, United States Code.

c. Any retirement program or account included in any successor or similar provision that may be enacted and determined to be exempt from tax under the Internal Revenue Code of 1986.

d. Any other retirement plans, contracts, or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

65.30(8) *Education accounts.* Exclude from resources the value of:

a. Any funds in a qualified tuition program described in Section 529 of the Internal Revenue Code of 1986 or in a Coverdell Education Savings Account under Section 530 of the Internal Revenue Code.

b. Any other education plans, contracts or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

441—65.31(234) Homeless meal providers. When a local office of the department is notified that an establishment or shelter has applied to be able to accept food assistance benefits for homeless persons, staff shall obtain a written statement from the establishment or shelter. The statement must contain information on how often meals are served by the establishment or shelter, the approximate number of meals served per month, and a statement that the establishment or shelter does serve meals to homeless persons. This information must be dated and signed by a person in charge of the administration of the establishment or shelter and give the person's title or function with the establishment.

The establishment or shelter shall cooperate with agency staff in the determination of whether or not meals are served to the homeless.

441—65.32(234) Basis for allotment. The minimum benefit amount for all eligible one-member and two-member households shall be 8 percent of the maximum monthly allotment for a household size of one member.

441—65.33(234) Dependent care deduction. Households shall be allowed a deduction for the amount of monthly dependent care expenses.
[**ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—65.34(234) Exclusion of advance earned income tax credit payments from income. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.35(234) Migrant and seasonal farm worker households. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.36(234) Electronic benefit transfer (EBT) of food stamp benefits. Rescinded IAB 3/5/03, effective 5/1/03.

441—65.37(234) Eligibility of noncitizens. The following groups of aliens who are lawfully residing in the United States and are otherwise eligible are eligible for food assistance benefits:

65.37(1) Aliens who are receiving benefits or assistance for blindness or disability as specified in 7 CFR 271.2, as amended to April 6, 1994, regardless of their immigration date.

65.37(2) Aliens who have been residing in the United States for at least five years as legal permanent residents.

65.37(3) Aliens who hold one of the following statuses:

a. A refugee admitted under Section 207 of the Immigration and Nationality Act.

b. A Cuban or Haitian entrant admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.

c. An Amerasian immigrant admitted under Section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act.

d. An asylee admitted under Section 208 of the Immigration and Nationality Act.

e. An alien whose deportation or removal has been withheld under Section 243(h) or 2411(b)(3) of the Immigration and Nationality Act.

65.37(4) Aliens aged 18 or under, regardless of their immigration date. The department shall exclude the income and resources of a sponsor when determining food assistance eligibility and benefits for an alien aged 18 or under.

441—65.38(234) Income deductions. Notwithstanding anything to the contrary in these rules or regulations, student households cannot receive an income deduction for dependent care expenses that were excluded from educational income.

441—65.39(234) Categorical eligibility.

65.39(1) Notwithstanding anything to the contrary in these rules or in federal regulations, a household in which all members are recipients of a state or local general assistance (GA) program is subject to categorical eligibility provisions of the food assistance program provided that the state or local program:

a. Has income limits at least as stringent as the food assistance gross income test; and

b. Gives assistance other than one-time emergency payments that cannot be given for more than one continuous month.

65.39(2) Notwithstanding anything to the contrary in these rules or in federal regulations, a household is subject to categorical eligibility provisions of the food assistance program for any month in which the household is determined eligible for the Iowa promoting healthy marriage program pursuant to rule 441—47.2(234).

[**ARC 9173B**, IAB 11/3/10, effective 1/1/11]

441—65.40(234) Head of the household. Rescinded IAB 8/11/99, effective 11/1/99.

441—65.41(234) Actions on changes increasing benefits. Action on changes resulting in an increase in benefits will take place after the verification is received.

441—65.42(234) Work transition period. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.43(234) Household composition. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.44(234) Reinstatement.

65.44(1) The department shall reinstate assistance without a new application when the element that caused termination of a case no longer exists and eligibility can be reestablished prior to the effective date of cancellation.

65.44(2) When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date all information required to establish eligibility is provided.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.45(234) Conversion to the X-PERT system. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.46(234) Disqualifications. Notwithstanding anything to the contrary in these rules, food assistance program violation disqualifications for persons who are not participating in the food assistance program shall be imposed in the same manner as program violation disqualifications are imposed for persons who are participating in the food assistance program.

65.46(1) *First and second violations.* Notwithstanding anything to the contrary in these rules or regulations, the disqualification penalty for a first intentional program violation shall be one year except for those first violations involving a controlled substance. The disqualification penalty for a second intentional violation and any first violation involving a controlled substance shall be two years.

65.46(2) *Conviction on trafficking in food assistance benefits.* The penalty for any individual convicted of trafficking in food assistance benefits of $500 or more shall be permanent disqualification.

65.46(3) *Receiving or attempting to receive multiple benefits.* An individual found to have made a fraudulent statement or representation with respect to identity or residency in order to receive multiple benefits shall be ineligible to participate in the food assistance program for a period of ten years.

65.46(4) *Fleeing felons and probation or parole violators.* Rescinded IAB 10/3/01, effective 10/1/01.

65.46(5) *Conviction of trading firearms, ammunition or explosives for benefits.* The penalty for any individual convicted of trading firearms, ammunition or explosives for food assistance benefits shall be permanent disqualification.

441—65.47(234) Eligibility of noncitizens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.48(234) Sponsored aliens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.49(234) Providing information to law enforcement officials. Rescinded IAB 10/3/01, effective 10/1/01.

441—65.50(234) No increase in benefits. When a household's means-tested federal, state, or local public assistance cash benefits are reduced because of a failure to perform an action required by the public assistance program, the department shall reduce the household's food assistance benefit allotment by 10 percent as provided for in federal regulations at 7 CFR 273.11(j), (k), and (l) as amended to June 1, 2001, for the duration of the other program's penalty.

441—65.51(234) State income and eligibility verification system. The department shall maintain and use an income and eligibility verification system (IEVS) as specified in 7 CFR 272.8 as amended to November 21, 2000.

441—65.52(234) Systematic alien verification for entitlements (SAVE) program. The department shall participate in the SAVE program established by the U.S. Bureau of Citizenship and Immigration Service (BCIS) as specified in 7 CFR 272.11 as amended to November 21, 2000, in order to verify the

validity of documents provided by aliens applying for food assistance benefits with the central data files maintained by BCIS.

These rules are intended to implement Iowa Code section 234.12.

441—65.53 to **65.100** Reserved.

DIVISION II
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2 Subrules 65.8(11) and 65.108(11) effective 1/1/97.

CHAPTER 66
EMERGENCY FOOD ASSISTANCE PROGRAM

PREAMBLE

This chapter sets forth the rules governing the emergency food assistance program in Iowa. The Iowa department of human services has been designated by the governor as the agency responsible for administration of the emergency food assistance program. The department is responsible for receiving, storing, distributing, and accounting for foods donated through the U.S. Department of Agriculture (USDA).

For information about the emergency food assistance program and other food distribution programs, contact the Iowa Department of Human Services, Division of Financial, Health, and Work Supports, Food Distribution Program Manager, 1305 East Walnut Street, Des Moines, Iowa 50319-0114; telephone (515)281-5410. Clarifications of federal policy may be obtained by referencing 7 CFR Part 251 and 7 CFR Part 250, when applicable.

441—66.1(234) Definitions.

"Bonus items" means USDA-donated commodities that are so designated by USDA, are offered by USDA to the states as a one-time offer, and are not charged or credited against a state's entitlement.

"Charitable institution" means a facility that is public or private, nonprofit, and tax-exempt under the Internal Revenue Code as documented by a letter of exemption; is not a penal institution (including a correctional institution that conducts rehabilitation programs); and provides food assistance to needy persons.

"Commodities" means foods donated or available for donation by the USDA.

"Contract" means a formal, written agreement between the department and an eligible recipient agency regarding receiving, storing, handling, and distributing commodities.

"Contractor" means an eligible recipient agency that has entered into a contract with the department regarding storing, handling, and distributing commodities.

"Department" means the Iowa department of human services.

"Distribution site" means a location where an eligible recipient agency actually distributes commodities to needy persons for home consumption or serves prepared meals to needy persons.

"Eligible recipient agency" means a charitable institution that has entered into a contract with the department for the receipt of commodities or administrative funds or has entered into an agreement with another eligible recipient agency that has signed such a contract with the department. Eligible recipient agencies may include food banks, food pantries, soup kitchens, hunger relief centers, hospitals, retirement homes, Nutrition Services Incentive Programs that operate congregate meals sites or provide home-delivered meals (to the extent that they serve predominately needy persons), summer camps for children or child nutrition programs providing food service, and disaster relief programs. An eligible recipient agency shall meet federal requirements as described at 7 CFR 251.3(d) and 7 CFR 251.5(a), as published on January 1, 2005.

"Emergency feeding organization" means an eligible recipient agency that provides nutrition assistance to relieve situations of emergency and distress through the provision of food to needy persons, including low-income and unemployed persons, under an agreement with the department. Emergency feeding organizations can include food banks, food pantries, soup kitchens, emergency shelters, and hunger relief centers.

"FNS" means the Food and Nutrition Service, a division of the USDA that administers food assistance programs.

"Food bank" means a public or charitable institution that maintains an established operation involving the provision of food or edible commodities or the products thereof to food pantries, soup kitchens, hunger relief centers, or other food or feeding centers that, as an integral part of their normal activities, provide meals or food to needy persons on a regular basis.

"Food distribution program" means the office in the department's division of financial, health, and work supports that is responsible for administering the FNS food distribution programs.

"Food pantry" means a public or private nonprofit organization that distributes food to low-income and unemployed households to relieve situations of emergency and distress.

"Household" means a single individual living alone or a group of related or nonrelated individuals who live together, who are not boarders or residents of an institution, and who purchase and prepare food for home consumption.

"Program manager" means a department employee who is assigned to fulfill department responsibilities for management of the USDA FNS food distribution programs.

"Soup kitchen" means a public or charitable institution that provides prepared food to needy homeless persons on a regular basis as a part of its normal activities.

"Subcontract" means a contract between a contractor, as defined in this chapter, and another eligible recipient agency.

"Subcontractor" means an eligible recipient agency that has entered into a subcontract with a contractor, as defined in this chapter.

"Subsidiary distributing organization" means an eligible recipient agency that holds a contract with the department and is also under subcontract with another eligible recipient agency for the distribution of federal commodities.

"TEFAP" means The Emergency Food Assistance Program as authorized by the Emergency Food Assistance Act of 1983 as amended through Public Law 107-249, enacted October 23, 2002.

"USDA" means the United States Department of Agriculture.

441—66.2(234) Application to be a TEFAP contractor. An organization that seeks to be a TEFAP contractor shall submit a written request to the Iowa Department of Human Services, Division of Financial, Health, and Work Supports, Food Distribution Program Manager, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The written request shall contain sufficient information about the applicant to enable the department to determine whether the applicant qualifies to be an eligible recipient agency as defined at 441—66.1(234).

66.2(1) *Determination of eligibility.* Within ten days of receipt of an applicant's written request to be a TEFAP contractor, the program manager shall notify the applicant in writing of the department's decision. The department shall approve an applicant's request to be a TEFAP contractor only when both of the following are true:

a. The applicant qualifies to be an eligible recipient agency as defined at 441—66.1(234).

b. A contract with the applicant, in addition to those eligible recipient agencies currently under contract with the department, will allow the department to distribute commodities in Iowa to needy individuals or households in the most cost-effective and comprehensive manner possible.

66.2(2) *Administrative review of denial of eligibility.* When an applicant's request to be a TEFAP contractor is denied by the program manager, the applicant may request an administrative review by sending a letter requesting review of the denial to the administrator of the division of financial, health, and work supports. The applicant shall send the letter within five days of receipt of the letter of denial.

a. When more information is needed, the administrator shall request the information within five days of receipt of the request for review.

b. The administrator shall review the denial and shall issue a decision within ten days of the request for review or of the receipt of additional information, whichever is later.

c. When the division administrator reverses the denial, the applicant shall be given the opportunity to negotiate a TEFAP contract.

441—66.3(234) Contracts. A contract between the department and an eligible recipient agency approved as described at subrule 66.2(1) shall cover receiving, storing, handling, and distributing commodities. A contract may also cover the issues of receiving, storing, handling, and distributing commodities through a subsidiary distributing organization that holds a subcontract with a contractor. A TEFAP contract shall include, but is not limited to, the following items:

66.3(1) *Subcontractors subject to contract provisions.* A contractor shall ensure that its subsidiary distributing organizations, if any, and other subcontractors that the organizations serve are subject to all the provisions of the contract between the department and the contractor.

66.3(2) *Oversight.* A contractor shall oversee each subcontractor that the contractor serves.

66.3(3) *Program documentation.* A contractor shall maintain a file on each subcontractor that the contractor serves, documenting the programs of the subcontractor and the procedures the subcontractor uses to determine household eligibility under the policies described at 441—66.5(234).

66.3(4) *Issue rates.* A contractor shall determine the issue rates for each subcontractor that the contractor serves, based on the subcontractor's:

a. Ability to distribute without waste;

b. Anticipated use based on inventory records and controls; and

c. Ability to accept and store commodities.

66.3(5) *Maintenance of expenditures.* Each contractor and subcontractor shall maintain its normal expenditures for food with no reduction due to receipt of commodities.

66.3(6) *Distribution to low-income households.* A contractor or subcontractor that distributes commodities to households must limit the distribution of commodities to households that meet the eligibility criteria as described at 441—66.5(234).

66.3(7) *Meal sites serving needy persons.* A contractor or subcontractor that provides prepared meals must demonstrate that it serves predominantly needy persons. The agency is not required to employ a means test or to keep records solely for the purpose of demonstrating that its recipients are needy.

441—66.4(234) Distribution. The department is the agency responsible for food distribution in Iowa under TEFAP. TEFAP commodities and funds are allocated and delivered to Iowa by the USDA according to the USDA formula as defined at 7 CFR 251.3(h), as published on January 1, 2005.

66.4(1) *Distribution contractors.* The department shall enter into a contract for distribution of commodities with a qualified eligible recipient agency approved as described at subrule 66.2(1) to distribute commodities in Iowa to needy individuals or households in the most cost-effective and comprehensive manner possible.

a. *Subcontractors.* TEFAP contractors may subcontract with other eligible recipient agencies for distribution of commodities.

b. *Emergency feeding organizations.* In the distribution of commodities, the department shall give priority to eligible recipient agencies that are emergency feeding organizations. If the need arises, the department shall implement a priority system to serve predominately needy persons.

c. *Use of subsidiary distributing organizations.* A contractor may furnish services through another eligible recipient agency as a subsidiary distributing organization, provided that the contractor has a written contract with the subsidiary distributing organization.

66.4(2) *Allocation to contractors.* The department shall make commodities available for distribution to contractors in accordance with the provisions of 7 CFR Part 251, as published on January 1, 2005, and of 7 CFR Part 250, as published on January 1, 2005, when the provisions of Part 250 are not inconsistent with 7 CFR Part 251.

a. *Timing of allocation.* To the extent possible, the department shall allocate commodities to the contractors each month.

b. *Basis for allocation.* The allocation of commodities to each contractor is based on the percentage of the Iowa residents with income at or below 185 percent of the federal poverty level who live in the area that each contractor serves.

66.4(3) *Variations in distribution.* The department may withhold or reduce the delivery of commodities to contractors under the following circumstances:

a. When commodities are not available or have not been transported to the state in time for delivery;

b. When the commodities inventory is not sufficient to meet all requests;

c. When an eligible recipient agency has commodities on hand in excess of the amount that could be used without waste in providing services for the number of needy persons served;

d. When the state's supply is depleted; or

e. When the department or USDA has issued orders restricting distribution of certain food items.

66.4(4) *Special provisions for situations of disaster and distress.* The department reserves the right to distribute commodities in situations of disaster, emergency, or distress to any affected area in Iowa. In these situations, the department shall use commodities in the central warehouse first and shall then, if necessary, use commodities from the inventory of each contractor. Federal regulations at 7 CFR 250.43 and 7 CFR 250.44, as published on January 1, 2005, shall apply in these situations.

441—66.5(234) Household eligibility. Household eligibility is determined by residence, household size, and income.

66.5(1) *Residence.* Household members shall be residing in the state of Iowa.

66.5(2) *Household size.* Household size is determined by the number of people living in a dwelling, excluding boarders, as household is defined at 441—66.1(234).

66.5(3) *Income eligibility.* All earned and unearned income of the household shall be considered in determining eligibility.

a. *Income defined.* Income means all income received by an individual from sources identified by the U.S. Census Bureau in computing median income and includes:

(1) Money wages or salary;
(2) Net income from nonfarm self-employment;
(3) Net income from farm self-employment;
(4) Dividends;
(5) Interest;
(6) Income from estates or trusts;
(7) Net rental income and royalties;
(8) Public assistance or welfare payments;
(9) Pensions and annuities;
(10) Workers' compensation;
(11) Alimony;
(12) Child support;
(13) Veterans' pensions;
(14) Social security;
(15) Railroad retirement;
(16) Supplemental security income;
(17) State or federal assistance;
(18) Veterans' benefits;
(19) Black lung benefits;
(20) All disability pensions;
(21) State supplementary assistance;
(22) Unemployment compensation benefits; and
(23) Income from minors under 16 years of age.

b. *Determination of income.* Earned or unearned income shall be the gross annual, monthly, or weekly income.

(1) Biweekly income shall be multiplied by 2.15 to determine monthly income.
(2) Adjusted gross self-employment income shall be averaged over a 12-month period.
(3) Income received from interest and dividends shall be averaged over a 12-month period.
(4) The amount of income that stops or starts during the month shall be estimated based on the best information available.

c. *Income exclusions.* When calculating total household income for this program, all income shall be excluded that is specifically excluded for food assistance by federal statute, especially those sources listed in federal regulations at 7 CFR 273.9(c)(10) as published on January 1, 2005.

d. *Income guidelines.* Households are eligible for TEFAP when the countable household income is at or below 185 percent of the federal poverty guidelines. These federal guidelines are revised annually, effective every July 1. The department shall forward these income guidelines annually to contractors.

441—66.6(234) Reimbursement for allowable costs. To the extent that funds are available for payment, the department shall pay allowable costs to contractors as reimbursement for expenses attributable to the program. TEFAP payments by the department are subject to federal regulations at 7 CFR Part 251, as published on January 1, 2005, especially 7 CFR 251.8(e).

66.6(1) *Allowable costs.* "Allowable costs" are the direct costs incurred for intrastate storage and transportation of federal commodities. Allowable costs shall include:

a. Costs to rent, lease, operate, and maintain storage facilities and transportation equipment;

b. Costs to load, unload, distribute, and otherwise handle, account for, and manage the distribution of federal commodities;

c. Salary and support expenses of employees and operations necessary in the management, coordination, and accomplishment of TEFAP food distribution to the extent that expenses are directly attributed to the storage and distribution of federal commodities;

d. Costs associated with determinations of eligibility, verification, and documentation;

e. Costs of providing information to persons receiving commodities concerning the appropriate storage and preparation of such commodities; and

f. Costs of other administrative procedures required for participation in the program.

66.6(2) *Reimbursement request.* Contractors must complete Form 470-0298, Federal Emergency Assistance Food Distribution Report/Reimbursement Request, in order to file for reimbursement.

66.6(3) *Rate of reimbursement.* The department shall reimburse each contractor at a per-gross-pound rate to be determined by the department and included in the agreement with the contractor. In the event the department cannot maintain this level of reimbursement throughout the term of the contract, the reimbursement shall be adjusted based on the available funds remaining from the USDA grant.

66.6(4) *No reimbursement for bonus items.* The department shall not reimburse a contractor for bonus items received. The department cannot project the amount and items received as bonus items throughout the year. Each contractor or subcontractor shall have the option to refuse bonus items.

441—66.7(234) Commodity losses and claims. Commodities which cannot be demonstrated by appropriate records or other satisfactory evidence to have been delivered to, or to be available in good condition for delivery to, eligible recipient agencies for which they were intended are considered to be lost commodities.

66.7(1) *Circumstances of loss.* Commodities may be lost through one or more of the following means:

a. Theft, damage, spoilage, or infestation in transit or in storage.

b. Improper distribution to institutions, families, or individuals or distributing above authorized rates.

c. Sale or exchange of commodities or diversion to an improper use.

d. Failure to deliver end products according to contracted yields under a processing agreement.

e. Other similar causes.

66.7(2) *Reporting commodity losses.* All commodity losses regardless of the dollar value shall be reported to the program manager by the responsible entity such as, but not limited to, contractors and subcontractors, warehouses, or carriers.

66.7(3) *Determination of fault and claim procedures.* The program manager shall investigate the commodity loss and determine who is at fault.

a. *Losses exceeding $100.* The department shall initiate a claim action against an entity that has been determined to be at fault if the value of the accumulated commodity loss exceeds $100. EXCEPTION: If there is evidence of violation of a federal or state statute, procedures in subrule 66.7(7) shall apply.

b. *Losses exceeding $2,500.* When the department believes that a claim exists against an entity and the value of the lost commodities exceeds $2,500, the department shall immediately refer the claim

determination to the FNS regional office. When the department receives notice from FNS that a claim exists, the department shall immediately initiate the claim procedure.

c. *Losses occurring in transit.* A claim action must be initiated regardless of the value of the commodity losses if the commodity losses occur when in transit for delivery.

d. *Demand letters.* The department shall send up to three demand letters to the entity determined responsible for the loss.

e. *Late charge.* Interest shall be assessed against an entity beginning on the thirty-first day following the date of the first demand letter. Interest shall be assessed at the rate determined by the U.S. Treasury Department at the beginning of each fiscal quarter.

66.7(4) *Claims payment.* The claim shall be paid to the food distribution program.

a. Cash payment will be accepted.

b. Replacement with like items may be used in lieu of cash payment for losses with the approval of the program manager. Approval shall not be granted if the replacement in kind would result in further losses or if the inventory is already in excess. A claim for the loss of bonus items may not be paid through replacement in kind.

66.7(5) *Administrative review of claim.* An entity may request an administrative review of a claim by sending a letter requesting review of the claim and a copy of a demand letter to the administrator of the division of financial, health, and work supports within 20 days of receipt of its first demand letter.

a. When more information is needed, the administrator shall request the information within 5 days of receipt of the request for review of the claim.

b. The administrator shall review the claim and issue a decision affirming, altering, or reversing the claim decision within 10 days of the request for the review or the receipt of additional information, whichever is later.

66.7(6) *Failure to make restitution.* Failure to make restitution when requested is cause for cancellation of the contract.

66.7(7) *Referral for violation of federal or state statute.* In instances of suspected violation of federal or state statute such as, but not limited to, embezzlement, misapplication, theft or fraud of any funds or commodities from the program, the department shall refer the case to the FNS.

441—66.8(234) State monitoring. The department shall annually review at least 25 percent of the TEFAP contractors and 10 percent of other eligible recipient agencies receiving commodities as subcontractors or 20 agencies, whichever is fewer. The department may contract with another entity to carry out these activities.

66.8(1) *Elements of review.* Reviews of contractors and subcontractors shall include a review of the following activities:

a. Eligibility determination.

b. Food ordering procedures.

c. Storage and warehousing practices.

d. Inventory control.

e. Approval of distribution sites.

f. Reporting.

g. Record-keeping compliance.

66.8(2) *Report of findings.* When a review of a contractor or subcontractor is completed, the department shall submit a report of findings to the agency that shall include:

a. A description of each deficiency found and contributing factors.

b. Any requirements for corrective action.

c. A timetable for establishing and completing a corrective action plan.

66.8(3) *Monitoring of corrective action.* The department shall monitor the corrective action activities of each contractor or subcontractor that has a corrective action plan.

441—66.9(234) Limits on unrelated activities. Contractors and subcontractors shall ensure that activities unrelated to the distribution of foods are conducted in a manner consistent with the limits in subrule 66.9(1).

66.9(1) *Allowable activities.* Activities unrelated to the distribution of foods may be conducted at distribution sites in the following circumstances:

a. Not part of commodity distribution. The persons conducting the activity shall make clear to commodity recipients that the activity is not part of commodity distribution and is not endorsed by the department.

(1) Impermissible activities include, but are not limited to, information not related to commodity distribution placed in or printed on bags, boxes, or other containers in which commodities are distributed.

(2) Recipes or information about commodities, dates of future distributions, hours of operations, or other federal, state, or local government programs or services for the needy may be distributed without a clarification that the information is not endorsed by the department.

b. Cooperation not required for receipt of commodities. The persons conducting the activity shall make clear to commodity recipients that cooperation is not a condition of the receipt of the commodities. Cooperation includes, but is not limited to, contributing money, signing petitions, or conversing with the person.

c. Does not disrupt or interfere with the distribution of commodities. The activity shall not be conducted in a manner that disrupts the distribution of the commodities.

66.9(2) *Termination of contract.* Except as provided in subrule 66.9(3), the department shall immediately terminate from further participation in commodity distribution any contractor or subcontractor that distributes or permits distribution of materials in a manner inconsistent with the provisions of subrule 66.9(1).

66.9(3) *Exception to termination of contract.* The department may withhold termination of a contract if the department cannot find another eligible recipient agency to operate the distribution in the area served by the violating organization. In these circumstances, the department shall monitor the distribution of commodities by the violating organization to ensure that no further violations occur.

441—66.10(234) Complaints.

66.10(1) *Complaints regarding commodities.* Each contractor or subcontractor shall immediately advise the department in writing of any complaints regarding commodities. The contractor or subcontractor shall provide complete information pertaining to the product and reason for complaint so that the department or USDA can conduct a proper investigation.

66.10(2) *Complaints regarding eligible recipient agencies.* A contractor shall promptly investigate any complaints it receives about the contractor or its subcontractors. Within ten days of receipt of the complaint, the contractor shall forward to the department a written report of the findings and the action taken. The department reserves the right to conduct an investigation if deemed necessary.

These rules are intended to implement Iowa Code section 234.12.

[Filed 11/16/05, Notice 9/28/05—published 12/7/05, effective 1/11/06]

CHAPTERS 67 to 70
Reserved

CHAPTER 71
EMERGENCY FOOD DISTRIBUTION PROGRAM
Rescinded, effective 11/1/86

CHAPTER 72
EMERGENCY FOOD AND SHELTER PROGRAM
Rescinded, effective 11/1/86

CHAPTER 73
COMMODITY DISTRIBUTION PROGRAMS
[Prior to 7/1/83, Social Services[770] Ch 73]
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 12/7/05, effective 1/11/06

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.
[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.1(249A,85GA,SF446) Definitions.

"Accountable care organization" means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients.

"Countable income" means "modified adjusted gross income" (MAGI) or "household income," as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

"Department" means the Iowa department of human services.

"Enrollment period" means the 12-month period for which eligibility is initially established.

"Essential health benefits" means the essential health benefits defined by the Secretary of the United States Department of Health and Human Services pursuant to Section 1302(b) of the Patient Protection and Affordable Care Act, Public Law 111-148.

"Exempt individuals" shall be defined pursuant to 42 CFR § 440.315.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Health insurance marketplace" or *"exchange"* means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

"Iowa Health and Wellness Plan" means the medical assistance program set forth in this chapter.

"Iowa wellness plan" means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

"Marketplace choice plan" means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

"Member" means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

"Minimum essential coverage" means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

"Modified adjusted gross income" means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

"Qualified employer-sponsored coverage" shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

"Qualified health plan" shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.
[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.2(249A,85GA,SF446) Eligibility factors. Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) *Persons covered.* Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;

b. Have countable income at or below 133 percent of the federal poverty level for their household size; and

c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and

d. Are not pregnant.

74.2(2) *Parents or caretakers of dependent children.* All dependent children under the age of 21 living with a parent or other caretaker relative must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or other caretaker relative's eligibility for Iowa Health and Wellness Plan benefits.

74.2(3) *Citizenship.* To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.3(249A,85GA,SF446) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.4(249A,85GA,SF446) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.5(249A,85GA,SF446) Enrollment period.

74.5(1) Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month following the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

74.5(2) Care provided before enrollment. No payment shall be made for medical care received before the effective date of enrollment.

74.5(3) Reinstatement. Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.6(249A,85GA,SF446) Reporting changes.

74.6(1) *Reporting requirements.* As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member turns 65.

d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.

e. The member's dependent child loses minimum essential coverage.

f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).

g. The member is confirmed pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A).

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.7(249A,85GA,SF446) Reenrollment. A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.8(249A,85GA,SF446) Terminating enrollment. Iowa Health and Wellness Plan enrollment shall end when any of the following occur:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
8. The member's dependent child loses minimum essential coverage.
9. The member's countable income exceeds 133 percent of the federal poverty level.
10. The member becomes pregnant.
11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.9(249A,85GA,SF446) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.10(249A,85GA,SF446) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. Coverage decisions and actions by participating marketplace choice plans shall be appealed through the plans' grievance and appeal processes. Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.11(249A,85GA,SF446) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to a $10 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during the first year of the Iowa Health and Wellness Plan.

74.11(2) Reserved.
[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.12(249A,85GA,SF446) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's countable income and health status.

74.12(1) *Iowa wellness plan services.* Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be an exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), prescription drugs and dental services consistent with 441—Chapter 78, and habilitation services consistent with rule 441—78.27(249A).

b. The Iowa Health and Wellness Plan provider network shall include all providers enrolled in the medical assistance program, including all participating accountable care organizations.

c. Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88. In addition to reimbursement for managed care pursuant to 441—Chapter 88, the department may provide care coordination fees, performance incentive payments, or shared savings arrangements for medical homes and accountable care organizations serving members enrolled in the Iowa Health and Wellness Plan.

d. When the member does not choose a primary medical provider, the department shall assign the member to a primary medical provider in accordance with the Medicaid managed health care mandatory enrollment provisions specified in 441—subrule 88.3(7) for mandatory enrollment counties and in accordance with quality data available to the department.

74.12(2) *Marketplace choice plan services.* Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level shall be enrolled in a marketplace choice plan unless the member is determined by the department to be an exempt individual. Marketplace choice coverage shall be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program. Individuals who have been determined eligible for the marketplace choice plan, but who have not yet been enrolled in a marketplace choice plan, shall receive fee-for-service coverage under the Iowa wellness plan until they choose or are assigned to a marketplace choice plan.

a. Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to Iowa Health and Wellness Plan members.

b. When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

c. The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible Iowa Health and Wellness Plan members. The department shall begin payment of the member's premiums for the first month of enrollment through the Iowa Health and Wellness Plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for the marketplace choice plan.

d. Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Dental services shall be provided through a contract with a commercial dental plan with covered services consistent with 441—Chapter 78. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

74.12(3) *Exempt individuals.* An Iowa Health and Wellness Plan member who has been determined by the department to be an exempt individual shall be given the choice of the benefits and service delivery

method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

74.12(4) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.

74.13(1) *Claims for services not provided by a qualified health plan.* Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80.

74.13(2) *Payment for services not provided by a qualified health plan.* Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department and the provider.

74.13(3) *Payment for services provided by the marketplace choice plan.* Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.14(249A,85GA,SF446) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—74.15(249A,85GA,ch138) Enrollment for IowaCare members.

74.15(1) Subject to a waiver of the eligibility requirements of 42 U.S.C. § 1396a(e)(14)(A) by the federal Centers for Medicare and Medicaid Services, and notwithstanding any other provision of this chapter, an individual who is enrolled in the IowaCare program under 441—Chapter 92 on October 1, 2013, shall be enrolled without an application in the Iowa Health and Wellness Plan effective January 1, 2014, if department records show:

a. That the income of all household members considered in determining the individual's eligibility for IowaCare (other than child support income) does not exceed 138 percent of the federal poverty level for a household of that size, based on the following sources of income information, in the following order of priority:

(1) Income used to determine eligibility for food assistance for the individual and other IowaCare household members, pursuant to 441—Chapter 92;

(2) Income used to determine eligibility for medical assistance for other IowaCare household members, pursuant to 441—Chapter 75;

(3) Iowa workforce development unemployment insurance benefit data available to the department pursuant to 441—paragraph 9.10(4)*"c"*;

(4) Iowa workforce development wage data available to the department pursuant to 441—paragraph 9.10(4)*"c"*;

(5) Income and eligibility verification system data available to the department pursuant to 441—paragraph 9.10(4)*"c"*; and

b. That the individual meets all eligibility requirements of the Iowa Health and Wellness Plan, pursuant to this chapter, other than income.

74.15(2) Individuals enrolled pursuant to this rule will thereafter be subject to all the provisions of this chapter, with no further application of this rule.

[**ARC 1214C**, IAB 12/11/13, effective 11/13/13; **ARC 1354C**, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]

[Filed ARC 1354C (Notice ARC 1213C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]

CHAPTER 75
CONDITIONS OF ELIGIBILITY

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

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.
[**ARC 1134C**, IAB 10/30/13, effective 10/2/13]

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

441—75.1(249A) Persons covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

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

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

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

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

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

(1) Failure to provide information, or

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

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

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. The state with the adoption assistance agreement:

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

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

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

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

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

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

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

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

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

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Outpatient hospital services.

2. Rural health clinic services (if contained in the state plan).

3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

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

(3) Meets one of the following:

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

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

3. Participates in a state perinatal program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

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

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

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

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

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

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

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

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

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

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

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)*"h,"* unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family's control.
4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.1(35) *Medically needy persons.*

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

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

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

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

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

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

b. *Resources and income of all persons considered.*

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

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

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

c. *Resources.*

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

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

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

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

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

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

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

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

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

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

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

e. Medically needy income level (MNIL).

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

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

Each additional person $116

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

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

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

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

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

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

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

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Care in an institution for mental disease.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The person is not otherwise eligible for Medicaid.

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

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

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

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

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

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

75.1(39) *Working persons with disabilities.*

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

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

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

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.

(4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)*"c."*

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)*"a"*(1) above.

(6) They have paid any premium assessed under paragraph 75.1(39)*"b"* below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social

security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

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

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

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$31
165% of Federal Poverty Level	$42
180% of Federal Poverty Level	$50
200% of Federal Poverty Level	$58
225% of Federal Poverty Level	$68
250% of Federal Poverty Level	$78
300% of Federal Poverty Level	$99
350% of Federal Poverty Level	$119
400% of Federal Poverty Level	$140
450% of Federal Poverty Level	$160
550% of Federal Poverty Level	$201
650% of Federal Poverty Level	$242
750% of Federal Poverty Level	$284
850% of Federal Poverty Level	$335
1000% of Federal Poverty Level	$404
1150% of Federal Poverty Level	$475
1300% of Federal Poverty Level	$556
1480% of Federal Poverty Level	$647

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

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

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

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

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

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

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

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

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

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

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

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

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

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

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

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

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

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

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

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

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

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It

includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

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

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

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

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

a. Medical assistance shall be available to people who:

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

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

(3) Are under the age of 65.

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

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

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

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

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

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

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

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

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

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer

screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

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

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

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

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

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

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

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

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

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

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

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

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

1. Denied presumptive eligibility by a qualified provider.

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

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

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

a. *Eligibility.* The following are eligible for assistance under this coverage group if they are not otherwise enrolled in Medicaid (other than IowaCare):

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

(2) Women who have reached childbearing age, are under 55 years of age, are capable of bearing children but are not pregnant, and have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

(3) Men who are under 55 years of age, who are capable of fathering children, and who have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

b. *Application.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The child is under 19 years of age.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.1(45) *Medicaid for former foster care youth.* Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

b. The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

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

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7833B**, IAB 6/3/09, effective 8/1/09; **ARC 7929B**, IAB 7/1/09, effective 7/1/09; **ARC 7931B**, IAB 7/1/09, effective 7/1/09; **ARC 8095B**, IAB 9/9/09, effective 10/14/09; **ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8261B**, IAB 11/4/09, effective 10/15/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 8713B**, IAB 5/5/10, effective 8/1/10; **ARC 8897B**, IAB 6/30/10, effective 9/1/10; **ARC 9581B**, IAB 6/29/11, effective 8/3/11; **ARC 9647B**, IAB 8/10/11, effective 8/1/11; **ARC 9956B**, IAB 1/11/12, effective 1/1/12; **ARC 0149C**, IAB 6/13/12, effective 8/1/12; **ARC 0579C**, IAB 2/6/13, effective 4/1/13; **ARC 0820C**, IAB 7/10/13, effective 8/1/13; **ARC 0990C**, IAB 9/4/13, effective 1/1/14; **ARC 1134C**, IAB 10/30/13, effective 10/2/13; **ARC 1482C**, IAB 6/11/14, effective 8/1/14]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in

the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

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

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

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

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

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

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

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

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

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

441—75.4(249A) Medical assistance lien.

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

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

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

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

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

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

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien

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

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

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

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

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

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

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

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

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

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

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

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

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

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

legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

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

75.4(4) Third party and provider responsibilities.

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

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

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

75.4(5) Department's lien.

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

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

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

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

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

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

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

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

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

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

75.5(1) Determining income from property.

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

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

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

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

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

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

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

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. *Notice and appeal rights.* The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. *Appeals.* Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2)*"d"* shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during

the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

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

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. *Eligibility.* A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. *Definition.* "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. *Estate recovery.* An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35and chapter 514H.

[**ARC 8443B**, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number.

75.7(1) As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

75.7(2) The requirement of subrule 75.7(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(3) If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13]

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

a. *Institutions.* For purposes of this rule, "institution" means an "institution" or a "medical institution" as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, "institution" also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. *Incapable of expressing intent regarding residency.* For purposes of this rule, an individual is considered to be "incapable of indicating intent regarding residency" if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or
3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

75.10(2) *Determination of residency.* State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

a. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

b. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to

that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

c. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

d. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

e. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

(1) Intends to reside, with or without a fixed address; or

(2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2)*"j."*

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2)*"k"* or *"l,"* the state of residence is:

(1) The state where the individual resides, with or without a fixed address; or

(2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2)*"j,"* with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.

5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);

2. Who is granted asylum in the United States under Section 208 of the INA;

3. Who is a refugee admitted to the United States under Section 207 of the INA;

4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;

5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;

6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;

7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);

8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);

9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);

10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;

11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or

12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

(3) A qualified alien under the age of 21.

(4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).

(5) An alien who has been granted asylum under Section 208 of the INA.

(6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

(11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).

(12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).

(13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);

2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or

3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

c. Except as provided in paragraph *"f,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d," "e,"* or *"i."* A reference to a form in paragraph *"d"* or *"e"* includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)*"i"*(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual

who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph *"d," "e,"* or *"i."* The retroactive months are outside the "reasonable period" during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2)*"e"*(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)*"e"*(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph *"d"* or *"e,"* satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph *"d"* or *"e."*

75.11(3) *Deeming of sponsor's income and resources.*

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8)*"b"* and a $1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

d. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7932B**, IAB 7/1/09, effective 7/1/09; **ARC 8096B**, IAB 9/9/09, effective 10/14/09; **ARC 8642B**, IAB 4/7/10, effective 6/1/10; **ARC 8786B**, IAB 6/2/10, effective 6/1/10; **ARC 9439B**, IAB 4/6/11, effective 6/1/11]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

75.12(1) *Suspension.* Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution; or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) *Coverage during suspension.* While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

75.12(3) *Reinstatement.* The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[**ARC 9957B**, IAB 1/11/12, effective 1/1/12]

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. *SSI policy reference.* The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. *Income considered.* For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. *Trust contributions.* Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. *Conditional eligibility.* For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. *Valuation of life estates and remainder interests.* In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule

75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

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

[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds $500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of $90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. *Personal needs in the month of entry.*

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. *Client's medical expenses.* A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

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

[**ARC 8444B**, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) *Multiple pregnancy.* If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) *Cost of examination.* When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children who are eligible only in a retroactive month.

e. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)*"c."*

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[**ARC 8786B**, IAB 6/2/10, effective 6/1/10]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2)*"b."*

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

a. Using the standards applicable to persons who are 18 years of age or older, and

b. Regardless of whether a review of the member's disability would otherwise be due.

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

[**ARC 9044B**, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in subrule 75.21(2).

75.21(2) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least $5 per month per household.

75.21(3) *Coverage of non-Medicaid-eligible family members.*

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(4) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34). Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

k. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

l. The health plan pays secondary to another plan.

m. The only Medicaid members covered by the health plan are currently in foster care.

n. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(5) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(6) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be

cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(7) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(9) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

(1) A premium rate, deductible, or coinsurance changes,

(2) A person covered under the policy loses full Medicaid eligibility,

(3) Changes in employment or hours of employment affect the availability of health insurance,

(4) The insurance carrier changes,

(5) The policyholder leaves the Medicaid home, or

(6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)*"a,"* shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(11) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(13) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(15) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(2) and 75.21(3).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 1447C**, IAB 4/30/14, effective 7/1/14]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in

the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. *Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. *Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. *Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. *Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage

for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2014, through June 30, 2015, this average statewide cost shall be $5,103.24 per month or $167.87 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless

the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)*"c"*);
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)*"d"*); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9)*"b"* and also meets the condition described in paragraph 75.23(9)*"c."*

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8444B**, IAB 1/13/10, effective 3/1/10; **ARC 8898B**, IAB 6/30/10, effective 7/1/10; **ARC 9404B**, IAB 3/9/11, effective 5/1/11; **ARC 9582B**, IAB 6/29/11, effective 7/1/11; **ARC 0192C**, IAB 7/11/12, effective 7/1/12; **ARC 0821C**, IAB 7/10/13, effective 7/1/13; **ARC 1484C**, IAB 6/11/14, effective 7/1/14]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be

assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2014, to June 30, 2015, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $4,666 per month.

(2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is $25,040 per month.

(3) The average statewide charge to a resident of a mental health institute is $20,498 per month.

(4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $6,297 per month.

(5) The average statewide charge to a home- and community-based waiver applicant or member shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8898B**, IAB 6/30/10, effective 7/1/10; **ARC 9582B**, IAB 6/29/11, effective 7/1/11; **ARC 0192C**, IAB 7/11/12, effective 7/1/12; **ARC 0822C**, IAB 7/10/13, effective 7/1/13; **ARC 0821C**, IAB 7/10/13, effective 7/1/13; **ARC 1484C**, IAB 6/11/14, effective 7/1/14; **ARC 1483C**, IAB 6/11/14, effective 7/1/14]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible" shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Member" shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, "member" shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member."

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of assets" shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

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

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days

after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

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

441—75.28(249A) Recovery.

75.28(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. "Client error" 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—76.15(249A).

"Department" means the department of human services.

"Premiums paid for medical assistance" means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

75.28(2) *Amount subject to recovery.* The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) *Notification.* All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures shall include:

(1) For whom assistance was paid;

(2) The period during which assistance was incorrectly paid;

(3) The amount of assistance subject to recovery; and

(4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums shall include:

(1) The amount of the premium; and

(2) The month covered by the medical assistance premium.

75.28(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under the age of 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.

75.28(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 persons with an intellectual disability, 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.

75.28(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

75.28(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 persons with an intellectual disability, 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 being 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 75.28(7)*"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 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 chapter 633C, the department shall reimburse the county on a proportionate basis.

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13]

441—75.29(249A) Investigation by quality control or the department of inspections and appeals. An applicant or member shall cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical 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.

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13]

441—75.30(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, members 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 75.30(7) may be restricted (locked-in) to receive services from a designated provider(s).

75.30(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

75.30(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 provider(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 75.30(3).

75.30(3) Payment will be made to a 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 75.30(5).

c. The designated provider refers the member 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 75.30(5).

75.30(4) When the member 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 member.

75.30(5) Members may change a designated provider(s) when a change is warranted, such as when the member has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the member shall make the determination when the member has demonstrated that a

change is warranted. Members may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

75.30(6) When lock-in is imposed on a member, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

75.30(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 members 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 75.30(7)*"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid member 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 members 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 members determined in paragraph 75.30(7)*"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 as 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.

[**ARC 1266C**, IAB 1/8/14, effective 1/1/14; **ARC 1355C**, IAB 3/5/14, effective 4/9/14]

441—75.31 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Needy specified relative" means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member's circumstances comes to the attention of a staff member.

75.52(3) *Forms.*

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) *Client responsibilities.* For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*

(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.

(2) Change of mailing or living address.

(3) Sources of income.

(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.

(2) The mailing or living address changes.

(3) A source of income changes.

(4) A health insurance premium or coverage change is effective.

(5) Of any change in income.

(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[**ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1)*"b"* as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, "education or training" means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4)*"b"*(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

[**ARC 0579C**, IAB 2/6/13, effective 4/1/13]

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)*"n"* or *"o,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)*"c"* reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate,

more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)*"d"* and 75.57(7)*"ag."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses

not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"*75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt

as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet

needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)*"b"* and 75.57(1)*"d."*

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)*"f."*

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related

Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."*

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10; **ARC 9043B**, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) *Exclusions from the eligible group.* In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) *Needs, income, and resource exclusions.* The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) *Medicaid entitlement.* Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2)*"a," "b,"* and *"c."*

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

441—75.61 to **75.69** Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI). Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing. From January 1, 2014, through June 30, 2014, subject to a waiver of the requirements of 42 U.S.C. § 1396a(e)(14) by the federal Centers for Medicare and Medicaid Services, use of MAGI and "household income" shall not be considered to be required by that section for persons otherwise eligible for family planning services under subrule 75.1(41).

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13; **ARC 1212C**, IAB 12/11/13, effective 1/1/14; **ARC 1356C**, IAB 3/5/14, effective 4/9/14]

441—75.71(249A) Income limits. Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	$447
		2	$716
		3	$872
		4	$1,033
		5	$1,177
		6	$1,330
		7	$1,481
		8	$1,633
		9	$1,784
		10	$1,950
		over 10	$1,950 plus $178 for each additional person
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

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CHAPTER 76
ENROLLMENT AND REENROLLMENT

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/1/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or "Medicaid" program and addresses related matters.

Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the department, a referral from a health insurance marketplace, an express lane eligibility determination, a Social Security Income eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination, as described in rules 441—76.2(249A) through 441—76.7(249A).

Reenrollment is based on a review, as described in rule 441—76.14(249A), of all eligibility factors under 441—Chapter 75.

Applicants and members are required to report changes pursuant to rule 441—76.15(249A).

Department action on information received will occur as described in rules 441—76.15(249A) and 441—76.16(249A).

Automatic redeterminations of eligibility will occur as described in rule 441—76.17(249A).

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.1(249A) Definitions.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Electronic account" means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

"Electronic case record" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid eligibility and enrollment.

"Health insurance marketplace" means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

"Medicare savings program" refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are qualified disabled and working people (QDWP) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(ii), qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(i), specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iii), and expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iv).

"Member" means an individual who has been determined eligible for medical assistance pursuant to 441—Chapter 75 and has been enrolled to receive assistance. For the medically needy program, "member" shall mean an individual who has been determined eligible for medical assistance under the medically needy program, has been enrolled, and has countable income at or below the medically needy income level (MNIL) or has reduced countable income to the MNIL during the certification period through spenddown.

"Modified adjusted gross income" means the methodology to determine income eligibility prescribed by 1902(e)(14) of the Social Security Act (42 U.S.C. § 1396a(e)(14)).

"Presumptive eligibility" means that a person is presumed to be eligible on a temporary basis based on information provided.

"Qualified entity" is an entity that is described in Paragraphs (1) through (10) of 42 CFR 435.1101 relating to coverage groups for children, 42 CFR 435.1110b relating to hospitals determining eligibility, U.S.C. § 1396r-1 relating to coverage groups for pregnant women, or 42 U.S.C. § 1396r-1b relating to the breast and cervical cancer coverage group, that has been determined by the department to be capable of making presumptive Medicaid eligibility determinations, and that has signed an agreement with the department as a qualified entity.

"Responsible person" means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"Supplemental security income" or *"SSI"* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

"WIC" is the Special Supplemental Nutrition Program for Women, Infants, and Children established by 42 U.S.C. § 1786.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.2(249A) Application with the department. This rule describes the process of applying for medical assistance directly with the department of human services.

76.2(1) *Application for eligibility effective prior to January 1, 2014.* Application for the Medicaid or HAWK-I program to be initially effective prior to January 1, 2014, must be made as provided in this subrule.

a. Forms.

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

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

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

b. Who can file. An application may be filed by the applicant, an adult in the applicant's household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by fax or by e-mail.

(2) Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals 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).

(4) An application for HAWK-I may be filed with the third-party administrator as provided at 441—subrule 86.3(3).

d. Minimum application requirements. A valid application is an application containing a legible name, a legible address, and a signature. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic and handwritten signatures transmitted via electronic transmissions are acceptable. An application that does not include a legible name, a legible address, and a signature will be rejected without a determination of eligibility.

e. Interviews.

(1) The department may require a face-to-face or telephone interview with adult applicants, authorized representatives, or responsible persons.

(2) The department shall notify the applicant, authorized representative, or responsible person of the date, time and method of an interview. This notice shall be provided to the applicant, authorized representative, or responsible person personally, by telephone, by e-mail, by mail or by fax.

(3) Failure of the applicant, authorized representative, or responsible person to attend a scheduled interview shall be a basis for denial of an application or cancellation of assistance for adults. Failure to attend an interview shall not serve as a basis for denial of an application or cancellation of assistance for children.

f. Additional information or verification needed to determine eligibility. The department shall notify the applicant, authorized representative, or responsible person in writing that additional information or verification is required to establish eligibility. This notice shall be provided to the applicant, authorized representative, or responsible person personally or by mail or fax.

(1) The department shall allow the applicant, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

(2) The department may extend the deadline for a reasonable period of time when the applicant, authorized representative, or responsible person is making every effort but is unable to secure the required information or verification.

(3) The application shall be denied if the department does not receive one of the following by the due date:

1. The information or verification,
2. An authorization for the department to obtain the information or verification, or
3. A request for an extension of the due date.

(4) If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant, authorized representative, or responsible person shall have until the next business day to provide the information.

76.2(2) *Application for eligibility effective on or after January 1, 2014.* Application for the Medicaid or HAWK-I program to be initially effective on or after January 1, 2014, must be made as provided in this subrule.

a. Form. Application for the Medicaid or HAWK-I program shall be submitted on Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

b. Who can file. An application may be filed by the applicant, an adult in the applicant's household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov or at www.dhsservices.iowa.gov or at the health insurance marketplace Web site at www.healthcare.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center, or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1-855-889-7985, or by e-mail or fax. Addresses, e-mail addresses and fax numbers of local offices of the department are available at www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html.

(2) An application may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals 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).

d. Minimum application requirements. Initial applications must be signed under penalty of perjury. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission are acceptable. An application that does not include a signature under penalty of perjury will be rejected without a determination of eligibility.

e. Additional information or verification needed to determine eligibility. The applicant must provide additional information or verification as requested by the department, including information or verification necessary to determine SSI-related Medicaid eligibility, as requested on SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

f. Interviews. The applicant, authorized representative, or responsible person may be required to attend a face-to-face or telephone interview to clarify information or to resolve conflicting information. Failure to attend a required interview will result in denial of the application.

76.2(3) *Date of filing.*

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1)*"c"* or 76.2(2)*"c."* When an application is delivered after business hours, it will be considered received on the next business day.

b. A valid application for Medicaid which is filed at a WIC office, a well child clinic, a maternal health clinic, an outstationed office, or the office of a qualified entity for presumptive Medicaid eligibility determinations shall be considered filed on the date it is received and date-stamped in one of those offices. When the application is received while the office is closed, it will be considered received on the next business day.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.3(249A) Referrals from a health insurance marketplace. Upon receipt of a referral from a health insurance marketplace indicating that an application filed with the health insurance marketplace has been screened and that the applicant has been found to be potentially eligible for Medicaid or HAWK-I, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The applicant is required to cooperate as described in this chapter for applications received directly by the department.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. § 1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department shall rely on a determination of the child's eligibility for food assistance pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.1(28) except for citizenship or alienage requirements, unless:

a. The child's household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in food assistance eligibility since that time, or

c. The household's income as calculated by the food assistance program exceeds the income limit for the mothers and children coverage group found at 441—subparagraph 75.1(28)*"a"*(1).

76.4(2) To obtain express lane enrollment for a child, the child's household must request medical assistance for the child on Express Lane Medicaid for Children, Form 470-4851 or Form 470-4851(S). The department shall send Form 470-4851 or Form 470-4851(S) to the household when a child eligible for express lane enrollment is approved for food assistance pursuant to 441—Chapter 65. An adult

member of the child's household or a child receiving food assistance as head of household must sign Form 470-4851 or Form 470-4851(S) and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child's food assistance effective date. Express lane eligibility begins on the first day of the month of the child's food assistance effective date.

76.4(5) Retroactive enrollment is available for any of the three months before the month of the child's food assistance effective date when the child:

a. Has medical bills for covered services that were received in that period, and

b. Would have been eligible for medical assistance benefits in the month services were received if the application for medical assistance had been made in that month and the eligibility determination was made without regard to food assistance eligibility.

76.4(6) After the initial express lane enrollment, all redeterminations of medical assistance eligibility shall be made without reliance on any food assistance eligibility determination.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the Social Security Administration indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient shall be required to complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), when additional information is necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information on this form.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.6(249A) Referral for Medicare savings program. Referrals received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date on which the referral is transmitted by the Social Security Administration shall be treated as the date of application. When requested to do so, the applicant must complete Medicare Savings Programs Additional Information Request, Form 470-4846, to provide additional information needed to determine Medicare savings program eligibility.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.7(249A) Presumptive eligibility. Individuals may be temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity pursuant to this rule.

76.7(1) *For eligibility effective prior to January 1, 2014.*

a. Applicants for presumptive eligibility for children will complete Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S).

b. Applicants for presumptive eligibility for pregnant women or for presumptive eligibility for breast and cervical cancer coverage group shall complete Health Services Application, Form 470-2927 or Form 470-2927(S).

76.7(2) *For eligibility effective on or after January 1, 2014.* Applicants for presumptive eligibility will complete Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

76.7(3) *How and where to file.* Applications for presumptive eligibility are filed at the office of a qualified entity for presumptive Medicaid eligibility determinations.

76.7(4) *Enrollment.* An individual is enrolled on the date that presumptive eligibility is determined by the qualified entity.

76.7(5) *Notice and appeal rights.* Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

76.7(6) *Full medical assistance eligibility determination.* All presumptive eligibility applications shall receive a full determination of eligibility for Medicaid or HAWK-I except for breast and cervical cancer and pregnant women coverage groups.
[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.8(249A) Applicant responsibilities.

76.8(1) *Accurate information.* Applicants are responsible to give complete and accurate information needed to establish eligibility.

76.8(2) *Time frames for providing information or verification.* Applicants shall have ten calendar days to supply the information or verification requested by the department.

76.8(3) *Extensions.* The applicant may request an extension of a reasonable period of time when the applicant is making every effort but is unable to secure the required information or verification.

76.8(4) *Failure to comply.* An application shall be denied if the applicant does not attend a required interview, if applicable under subrule 76.2(1) or 76.2(2), or if the department does not receive one of the following by the due date:

a. The information or verification,

b. An authorization to obtain the information or verification, or

c. A request for an extension of the due date.

76.8(5) *Grace period.* If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information.

76.8(6) *Referrals to the Social Security Administration.* When an applicant or member may be eligible for benefits from the Social Security Administration and is directed by the department to apply for such benefits, the applicant or member must make application for such benefits as described in rule 441—75.3(249A).
[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member. Except as provided in paragraph 76.9(1)*"a"* below, 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 has a personal interest in the applicant's or member's welfare. 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 subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

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

b. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

c. Copies of all departmental correspondence with the applicant or member shall be provided to the recognized responsible person.

76.9(2) *Authorized representative.* An individual or organization designated by a competent applicant or member, designated by a responsible person recognized pursuant to subrule 76.9(1), or

with other legal authority to do so may act on behalf of the applicant or member in the application process, renewal of eligibility, or for ongoing eligibility.

a. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant or member or the responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's behalf, complete and submit a renewal form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

b. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

c. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the Internet Web site, www.dhsservices.iowa.gov, by mail, by e-mail, by fax, or in person.

d. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by fax or other electronic transmission.

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

f. The power to act as an authorized representative based on a designation by an applicant, member, or responsible person is valid until the applicant, member, or responsible person modifies the authorization or notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the applicant's, member's, responsible person's, or authorized representative's signature as appropriate.

g. Copies of all departmental correspondence shall be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

b. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible person must sign an agreement that the provider, staff member, or volunteer will adhere to the regulations in Part 431, Subpart F of 42 CFR Chapter IV and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

c. The authorized representative or responsible person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible person represents.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or 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).
[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate if notices and other communications are to be provided by the department in an electronic format through the individual's electronic account, rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an e-mail to the individual notifying the individual of the notice or other communication.
[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.12(249A) Application not required.

76.12(1) *Adding a new person.*

a. Adding an eligible person. For members whose eligibility is based on the modified adjusted gross income methodology, a new application is not required when an eligible person is added to an existing Medicaid-eligible group. Such a 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.

b. Adding a person previously ineligible due to a failure to cooperate. 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.

c. Adding a person previously ineligible due to failure to provide a social security number. 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.

d. Adding a person who was voluntarily excluded. 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 excluded.

76.12(2) *Reinstatement after cancellation.* Eligibility for medical assistance may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

76.12(3) *Loss of HAWK-I eligibility.* In those instances where a child loses HAWK-I eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.
[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.13(249A) Initial enrollment.

76.13(1) *Enrollment date.* Applicants who have been determined to be eligible shall be enrolled by the department in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the first month for which eligibility has been determined, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations.

(2) Eligibility under the qualified Medicare beneficiary coverage group begins on the first day of the month after the month of decision.

(3) Eligibility for individuals approved for supplemental security income, programs related to supplemental security income, state supplementary assistance, or medical assistance benefits shall be effective on the first day of the 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.

(4) When a request is made to add a new person to the eligible group, medical assistance shall not be effective before the first of the month in which the request was made.

(5) When a request is made prior to January 1, 2014, to add to the eligible group a person who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), medical assistance for the person shall be effective no earlier than the first day of the month following the month in which the request was made.

b. *Care or services prior to enrollment.* No payment shall be made for medical care or services received prior to the effective date of enrollment.

76.13(2) *Retroactive enrollment.*

a. Except as provided in paragraphs 76.13(2)*"e"* and *"f,"* medical assistance shall be available for all or any of the three months preceding the month in which an application is filed to persons who:

(1) Have medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance 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 shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(2)*"a"* are met.

d. Persons enrolled in Medicaid based on receipt of supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

e. Exceptions to retroactive enrollment. This subrule does not apply to the following individuals:

(1) Individuals whose citizenship or alien status has not been verified even though they are eligible during a 90-day reasonable opportunity period.

(2) Individuals determined eligible only under presumptive Medicaid benefits.

(3) Individuals eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Individuals eligible only under the home- and community-based waiver services program.

f. Exceptions to length of retroactive enrollment. Individuals eligible for Medicaid only on the basis of eligibility for a state supplementary assistance program are only eligible for retroactive enrollment for the 30 days prior to the date of application. All other provisions of this subrule apply.

76.13(3) *Certification for services.* The department 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, with the following exceptions:

a. *Presumptive eligibility.* A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action, Form 470-2580 or 470-2580(S), that will include certification information.

b. *Emergency Medicaid for aliens.* An individual who is eligible only for limited emergency Medicaid for aliens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action, Form 470-0485 or Form 470-0485(S), that will include certification information.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.14(249A) Reenrollment. Reviews of all conditions of eligibility will occur for the purposes of determining continued enrollment in Medicaid.

76.14(1) *Reenrollment frequency.*

a. *Eligibility reviews for eligibility prior to January 1, 2014.*

(1) Eligibility reviews shall be made as often as circumstances indicate, but in no instance shall the period of time between reviews exceed 12 months.

(2) Eligibility reviews will be conducted using information contained in and verification supplied with the review form specified in 441—subrule 75.52(3).

(3) When the review form is issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the fifth calendar day of the following month.

(4) When the review form is not issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

b. Eligibility reviews for eligibility effective on or after January 1, 2014.

(1) Eligibility reviews for members whose eligibility is based on the modified adjusted gross income methodology, who are eligible for Medicaid related to reciprocity for a subsidized adoption, who are eligible for Medicaid programs that are solely state-funded, who are Medicaid-eligible based upon the receipt of Medicaid related to foster care at the time they aged out of foster care, and who are eligible based on breast or cervical cancer treatment shall be conducted once every 12 months and no more frequently.

(2) Eligibility reviews for other members shall be made as often as circumstances indicate, but in no instance shall the period of time between eligibility reviews exceed 12 months.

76.14(2) *Reenrollment process.*

a. Reenrollment process prior to January 1, 2014.

(1) Within ten working days from the date a written request is issued, the member shall supply, insofar as the member is able, additional information needed to establish continued eligibility.

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

2. 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.

(2) Information for the eligibility review shall be submitted on Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), with the following exceptions:

1. Persons whose eligibility for Medicaid is related to the family medical assistance program shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

2. Persons whose eligibility for Medicaid is related to supplemental security income and who are receiving state supplementary assistance shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

3. Persons whose eligibility for Medicaid is based on foster care, subsidized adoption or subsidized guardianship shall have continued eligibility determined by submission of Foster Care, Adoption and Guardianship Medicaid Review, Form 470-2914 or Form 470-2914(S).

4. Individuals whose eligibility is for the medically needy coverage group shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

5. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071. The member must submit the completed review form before the end of the eligibility period to any location specified in subparagraph 76.2(2)*"c"*(3).

(3) For SSI-related Medicaid for adults, the department may request a face-to-face or telephone interview. Failure of the member to attend a scheduled interview shall serve as a basis for cancellation of assistance for adults. Failure of the member to attend an interview shall not serve as a basis for cancellation of assistance for children.

(4) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all questions answered and is signed, dated and accompanied by verification as required in 441—paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

(5) Reinstatement. When medical assistance has been canceled for failure to return a completed review form, assistance may be reinstated without a new application if the department receives the completed form within 14 calendar days of the effective date of cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information. EXCEPTION: Members eligible for family planning services only who fail to submit Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A).

b. Reenrollment process effective on or after January 1, 2014.

(1) Reenrollment shall be based on information contained in the member's electronic case record or other more current information available through electronic data matches. The member will be notified of the determination of continued eligibility and the basis of the determination on Notice of Action, Form 470-0485 or Form 470-0485(S). If any information contained in Form 470-0485 or Form 470-0485(S) is inaccurate, the member must sign and return the notice with accurate information within 30 days of the date on the notice.

(2) When eligibility cannot be determined based on information in the electronic case record and data matches, the member will be provided with a prepopulated renewal form, MAGI Medicaid Renewal, Form 470-5168 or Form 470-5168(S), and will have 30 days from the date of the renewal form to sign and return the form with necessary information, with the following exceptions:

1. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071.

2. Members whose eligibility for Medicaid is not based on the modified adjusted gross income methodology shall complete and return Medicaid Review, Form 470-3118 or 470-3118(S), when requested to do so by the department. Members whose eligibility has been determined on the basis of age, blindness or disability must sign and return the notice within 30 days of the date on the notice and provide verification of income and resources before a determination of continued eligibility can be made.

(3) Enrollment will end when information or documentation necessary to complete the determination of continued eligibility is not returned within 30 days, with the exception that members eligible for family planning services only who fail to submit the completed Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A). The department shall notify the member on Notice of Action, Form 470-0485 or Form 470-0485(S).

(4) Reconsideration period. When medical assistance has been canceled for failure to return a completed prepopulated renewal form or other information necessary to determine continued eligibility, enrollment may be reinstated without a new application if the department receives the completed form within the three calendar months following the effective date of cancellation. Enrollment for up to three months of retroactive benefits is available when the conditions of subrule 76.13(2) are met.

(5) An individual whose eligibility is not based on the modified adjusted gross income methodology must attend a face-to-face or telephone interview if requested to do so by the department.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.15(249A) Report of changes. As a condition of enrollment and continued enrollment for medical assistance, applicants and members shall report changes in circumstances as required in this rule.

76.15(1) *Report of changes for eligibility prior to January 1, 2014.*

a. In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, members shall report changes as follows:

(1) At the annual review or upon the addition of an individual to the eligible group, members shall report any change in the following:

1. Income from all sources, including any change in care expenses.

2. Resources.

3. Members of the household.

4. School attendance.
5. A stepparent's recovery from an incapacity.
6. Mailing or living address.
7. Payment of child support.
8. Receipt of a social security number.
9. Payment for child support, alimony, or dependents as defined in 441—paragraph 75.57(8)*"b."*
10. Health insurance premiums or coverage.

(2) Applicants and members shall report any change in the following within ten calendar days of the change:

1. Members of the household.
2. Mailing or living address.
3. Sources of income.
4. Health insurance premiums or coverage.

(3) Members described at 441—subrule 75.1(35) shall also report any change in income from any source and any change in care expenses within ten calendar days of the change.

b. In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, members shall report any change in the following to the department within ten calendar days of the change. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

(1) Income from all sources.
(2) Resources.
(3) Members of the household.
(4) Recovery from disability.
(5) Mailing or living address.
(6) Health insurance premiums or coverage.
(7) Medicare premiums or coverage.
(8) Receipt of social security number.
(9) Gross income of the community spouse or of the 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).)
(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report when health insurance coverage begins, or when their living or mailing address changes, within ten calendar days.

76.15(2) *Report of changes for eligibility on or after January 1, 2014.* A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the modified adjusted gross income methodology, any change in the following must be reported:

(1) Income from all sources.
(2) Members of the household.
(3) School attendance.
(4) Mailing or living address.
(5) Receipt of a social security number.
(6) Health insurance premiums or coverage.
(7) Alien or citizenship status.

b. In coverage groups for which Medicaid eligibility is not determined using the modified adjusted gross income methodology, any change in the following must be reported. EXCEPTION: Persons actually

receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

(1) Income from all sources.

(2) Resources.

(3) Members of the household.

(4) Recovery from disability.

(5) Mailing or living address.

(6) Health insurance premiums or coverage.

(7) Medicare premiums or coverage.

(8) Receipt of social security number.

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

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

(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care or based on an adoption assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, receipt of a social security number, and termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

(1) Income from all sources.

(2) Mailing or living address.

(3) Receipt of a social security number.

(4) Health insurance coverage.

(5) Alien or citizenship status.

76.15(3) *Failure to report.* When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible shall be considered an overpayment and subject to recovery from the member.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility shall be evaluated and eligibility shall be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrule 76.13(1), action based on a change reported during a month shall be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in 441—subrule 7.7(1).

76.16(2) 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—76.12(249A).

76.16(3) When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.17(249A).

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13]

441—76.17(249A) Automatic redetermination of eligibility. 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:

76.17(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 rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month in which the information is received.

76.17(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 rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month in which the information is received.

76.17(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 § 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.

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These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.3, and 249A.4.

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CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[**ARC 0485C**, IAB 12/12/12, effective 2/1/13]

441—77.3(249A) Hospitals.

77.3(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) *Referral to health home services provider.* As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

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

[**ARC 0198C**, IAB 7/11/12, effective 7/1/12]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety's name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. *Amount of bond.* Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. *Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)"a"(1) before employment of a staff member who will provide direct care.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program

if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) *Definitions.*

"Guardian" means a guardian appointed in probate or juvenile court.

"Major incident" means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

b. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) *Case management.* The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) *Day habilitation.* The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a," "d," "g,"* or *"h."*

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic

mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) *Prevocational habilitation.* The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

77.25(9) *Supported employment habilitation.* The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule and the provider criteria of the Iowa Plan for Behavioral Health contractor must be enrolled through the Iowa Plan for Behavioral Health contractor as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. The Iowa Medicaid enterprise will enroll providers with Medicaid only when the provider is enrolled in the Iowa Plan for Behavioral Health. Payment for services will be made to a provider only when the provider is enrolled in the Iowa Plan for Behavioral Health and the provider is authorized to provide the services. This includes payments made by the Iowa Medicaid enterprise for services provided to members who are not eligible to enroll in the Iowa Plan for Behavioral Health.

a. The Iowa Plan for Behavioral Health contractor shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department or the Iowa Plan for Behavioral Health contractor may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) *Licensed independent social workers (LISW).* Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) *Licensed master social workers (LMSW).*

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(4) *Licensed mental health counselors (LMC).* Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(5) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both

case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

77.33(22) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.33(23) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 1149C**, IAB 10/30/13, effective 1/1/14]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules

77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:
1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:
1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and

significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the

notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be

implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37(13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.

2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h"* and subparagraph 77.37(23)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current

accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14]

441—77.38(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 653—Chapter 9,

b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and

c. Has experience treating serious and persistent mental illness.

77.38(3) *Registered nurses.* A nurse on the team shall:

a. Be licensed as a registered nurse under 655—Chapter 3, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(4) *Mental health service providers.* A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 645—Chapter 31, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master or independent social worker under 645—Chapter 280, and

(2) Has experience treating persons with serious and persistent mental illness.

77.38(5) *Psychologists.* A psychologist on the team shall:

a. Be licensed under 645—Chapter 240, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(6) *Substance abuse treatment professionals.* A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)*"i,"* and

b. Have at least three years of experience treating substance abuse.

77.38(7) *Peer specialists.* A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) *Community support specialists.* A community support specialist on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) *Case managers.* A case manager on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of "qualified case managers and supervisors" in rule 441—24.1(225C).

77.38(10) *Advanced registered nurse practitioners.* An advanced registered nurse practitioner on the team shall:

a. Be licensed under 655—Chapter 7,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.38(11) *Physician assistants.* A physician assistant on the team shall:

a. Be licensed under 645—Chapter 326,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers and each of their staff members involved in direct consumer service must have completed the department's online brain injury training course prior to service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2)

evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive

three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided

to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS intellectual disability waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—77.42(249A) Public health agencies. Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[**ARC 0358C**, IAB 10/3/12, effective 11/7/12]

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards:

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION:

The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in

441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) *Respite care providers.*

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)*"c."*

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1149C**, IAB 10/30/13, effective 1/1/14]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) *Qualifications.* A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. *Staffing.* At a minimum, a qualifying provider must fill the following roles:

(1) Designated practitioner.

(2) Dedicated care coordinator.

(3) Health coach.

(4) Clinic support staff.

b. *Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

c. *Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)*"a"*(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. *Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)*"a"*(3) or (4) must be integrated health homes that:

(1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);

(2) Have a direct agreement with the Iowa Medicaid managed behavioral health organization to provide health home services for members with SMI or SED;

(3) Coordinate all community and social support services needs for members enrolled in the health home; and

(4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) *Report on quality measures.* As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) *Selection.* As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[**ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0838C**, IAB 7/24/13, effective 7/1/13]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[**ARC 0360C**, IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0580C**, IAB 2/6/13, effective 4/1/13]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0580C**, IAB 2/6/13, effective 4/1/13]

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

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

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

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

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

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

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

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

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

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

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

f. Payment for vaccines available through the Vaccines for Children (VFC) program will be approved only if the VFC program stock has been depleted.

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

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

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

(1) Correction of a congenital anomaly; or

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

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

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

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

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

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

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

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

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

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

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

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

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

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

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

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

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

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

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

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

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

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

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

(2) Sets work standards.

(3) Establishes job description.

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

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

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

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

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

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

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

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

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

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

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

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

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

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by:

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

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

(1) In labor or childbirth, or

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

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

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

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

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

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

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

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

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

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

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

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

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

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

78.1(20) Transplants.

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

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

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary 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 for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the Iowa Medicaid enterprise medical services prior authorization unit. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14]

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

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

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

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

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

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

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

(2) Drugs used for anorexia, weight gain, or weight loss.

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

(4) Rescinded IAB 2/8/12, effective 3/14/12.

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

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

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

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

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

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

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12; **ARC 9981B**, IAB 2/8/12, effective 3/14/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

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

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

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

a. Recipient selection and education.

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

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

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

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

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

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

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

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

The team should consist of:

A surgeon director.

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

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

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

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

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

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

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

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

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

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

c. *Experience and survival rates.*

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

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

78.3(16) Skilled nursing care in "swing beds."

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

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)*"a."*

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member's LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

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

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

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

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

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

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

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

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

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

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

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

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

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

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

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

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

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

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

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

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

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

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

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

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

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

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

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

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross-reference 78.28(2)*"a"*(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2)*"a"*(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed,

the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) *Endodontic services.* Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)*"c"*)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) *Oral surgery—medically necessary.* Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross-reference 78.28(2)*"b"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross-reference 78.28(2)*"b"*(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross-reference 78.28(2)*"c"*)

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe

handicapping malocclusion with a score of 26 or above using the index from the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12; **ARC 0631C**, IAB 3/6/13, effective 5/1/13]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated

foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

This rule is intended to implement Iowa Code section 249A.4.

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services.* Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 0305C**, IAB 9/5/12, effective 11/1/12]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-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		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		
		724.8	Other symptoms referable to back, facet syndrome		
		729.1	Myalgia and myositis, unspecified		
		729.4	Fascitis, unspecified		
		738.40	Acquired spondylolisthesis		
		756.12	Spondylolisthesis		
		846.0	Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)		
		846.1	Sprains and strains of sacroiliac region, sacroiliac ligament		
		846.2	Sprains and strains of sacroiliac region, sacrospinatus (ligament)		
		846.3	Sprains and strains of sacroiliac region, sacrotuberous (ligament)		
		846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region		
		847.0	Sprains and strains, neck		
		847.1	Sprains and strains, thoracic		
		847.2	Sprains and strains, lumbar		
		847.3	Sprains and strains, sacrum		
		847.4	Sprains and strains, coccyx		

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and

other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.

b. Type of service to be rendered and the treatment modalities being used.

c. Frequency of the services.

d. Assistance devices to be used.

e. Date home health services were initiated.

f. Progress of member in response to treatment.

g. Medical supplies to be furnished.

h. Member's medical condition as reflected by the following information, if applicable:

(1) Dates of prior hospitalization.

(2) Dates of prior surgery.

(3) Date last seen by a physician.

(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

(5) Prognosis.

(6) Functional limitations.

(7) Vital signs reading.

(8) Date of last episode of instability.

(9) Date of last episode of acute recurrence of illness or symptoms.

(10) Medications.

i. Discipline of the person providing the service.

j. Certification period (no more than 62 days).

k. Estimated date of discharge from the hospital or home health agency services, if applicable.

l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week

(except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services

to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)*"k"* for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)*"n"* for prior authorization requirements.

78.10(2) *Durable medical equipment.* DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)*"f"* for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5)*"d"* for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5)*"g"* and *"j"* for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)*"j"* for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)*"a"* for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)*"c"* for prior authorization requirements.

Insulin infusion pump. See 78.10(5)*"b"* and 78.10(5)*"e"* for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)*"i"* for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*

Patient lift. See 78.10(5)*"h"* for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)*"f"* for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from

the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5)*"l"* for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See 78.10(3)*"c"* for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)*"e"* for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5)*"m"* for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

(1) Has a sip 'n puff attachment, or

(2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or

(3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

(1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and

(2) Needs upper body support while sitting, and

(3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary

in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)*"a"*(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 8993B**, IAB 8/11/10, effective 10/1/10; **ARC 9256B**, IAB 12/1/10, effective 1/1/11; **ARC 0632C**, IAB 3/6/13, effective 5/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one

ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Axis I disorder" means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the "Diagnostic and Statistical Manual IV-TR," Fourth Edition.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's Axis I disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. *Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. *Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) *Covered services.* Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

(1) Mileage reimbursement to the member, if the member is the driver.

(2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.

(3) Taxi service.

(4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.

(5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, the member must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation needs make the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;

(2) Whether a member-owned vehicle is in working mechanical order and is licensed;

(3) Whether the member has a valid driver's license and auto insurance;

(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

(5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;

(2) The one-way distance to or from the medical appointment is more than 50 miles;

(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both,

during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. *Closest medical provider.* Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. *Member scheduling obligations.* Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. *Abusive behavior.* Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

78.13(4) *Grievance procedure.* The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person."

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)*"b,"* the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 1264C**, IAB 1/8/14, effective 3/1/14]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job,

and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio.

Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours

in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist

of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. *Stable milieu.* The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. *Chronic mental illness.* Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the

same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient's prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(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.
[**ARC 0994C**, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan for Behavioral Health.

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Care coordinator" means the professional who assists members in care coordination as described in paragraph 78.53(1)*"b."*

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Integrated health home" means the provision of services to enrolled members as described in subrule 78.53(1).

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. *Need for assistance.* The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. *Income.* The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. *Needs assessment.* The member's case manager or integrated health home care coordinator has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. The designated case manager or integrated health home care coordinator shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. *Plan for service.* The department or the Iowa Plan for Behavioral Health contractor has approved the member's plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

f. Iowa Plan for Behavioral Health eligibility. Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

78.27(3) *Application for services.* The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. *Rights restrictions.* Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. *Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. *Plan approval.*

(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.

(2) For members who are not Iowa Plan-eligible, services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. *Scope.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Exclusions.*

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. *Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;

(6) Social and leisure skill development;

(7) Personal care; and

(8) Protective oversight and supervision.

b. *Exclusions.* Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. *Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;

(2) Physical and emotional health and development;

(3) Language and communication development;

(4) Cognitive functioning;

(5) Socialization and community integration;

(6) Functional skill development;
(7) Behavior management;
(8) Responsibility and self-direction;
(9) Daily living activities;
(10) Self-advocacy skills; or
(11) Mobility.

b. *Setting.* Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. *Duration.* Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. *Exclusions.* Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. *Scope.* Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. *Setting.* Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. *Exclusions.* Prevocational habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. *Scope.* Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or 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 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. *Setting.* Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department or the Iowa Plan for Behavioral Health contractor determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department or the Iowa Plan for Behavioral Health contractor will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. *Appeal rights.*

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 9311B**, IAB 12/29/10, effective 1/1/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)*"d."*

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)*"l."*

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)*"f."*

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)*"a."*

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)*"c"*)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)*"m."*

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)*"c."*

k. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)*"e."*

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)*"n."*

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)*"g."*

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)*"h."*

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)*"i."*

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)*"j."*

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)*"a"*(4).

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)*"b."*

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)*"d."*

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)*"e."*

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)*"f."*

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)*"g."*

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"b."*

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"d."*

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"c."*

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"e."*

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)*"k."*

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)*"l."*

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)*"m."*

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)*"n."*

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)*"a."*

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"b."*

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"c."*

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)*"d."*

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)*"g."*

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.

2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

3. Services provided to other persons in the member's household.

4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0631C**, IAB 3/6/13, effective 5/1/13; **ARC 0632C**, IAB 3/6/13, effective 5/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.

b. Outpatient surgery.

c. Laboratory, X-ray and other diagnostic services.

d. General or family medicine.

e. Follow-up or after-care specialty clinics.

f. Physical medicine and rehabilitation.

g. Alcoholism and substance abuse.

h. Eating disorders.

i. Cardiac rehabilitation.

j. Mental health.

k. Pain management.

l. Diabetic education.

m. Pulmonary rehabilitation.

n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. *Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, 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.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

441—78.33(249A) Case management services.

78.33(1) Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

a. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

78.33(2) Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)*"f"* and the skilled activities listed in paragraph 78.34(7)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual or agency that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

(1) Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled

as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) *General service standards.* All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)*"a,"* as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)*"f"* and the skilled activities listed in paragraph 78.37(15)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(5) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) *Assisted living on-call service.* The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

78.37(19) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group

counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8)*"f"* and the skilled activities listed in paragraph 78.38(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual or agency that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary

responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)*"f"*(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed $7,262 per the member's waiver year.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. *Activities to obtain a job.* Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)*"f"* and the skilled activities listed in paragraph 78.41(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member.

Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual or agency that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical

intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's

intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Unit of service. Except as provided in paragraph 78.41(14)*"b,"* the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. Exclusions.

(1) Services shall not be provided in the member's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)*"e"*(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the member's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case

manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)*"f"* and the skilled activities listed in paragraph 78.43(13)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual or agency that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are

not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed

need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law

employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning,

and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)*"f"* and the skilled activities listed in paragraph 78.46(1)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the individual or agency that will provide the components of the attendant care services.

(2) Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

(3) Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

(4) Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met.

If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).

2. Home and vehicle modification.

3. Specialized medical equipment.

4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. *Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0358C**, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program

providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working

with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. *Other service components.* Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. *Documentation of case management.* For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:
1. Having a body mass index (BMI) over 25 for an adult, or
2. Weighing over the 85th percentile for the pediatric population.
(7) Hypertension.
c. For purposes of this rule, the term "serious mental illness" means:
(1) A psychotic disorder;
(2) Schizophrenia;
(3) Schizoaffective disorder;
(4) Major depression;
(5) Bipolar disorder;
(6) Delusional disorder; or
(7) Obsessive-compulsive disorder.
d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.
[**ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0838C**, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[**ARC 0360C**, IAB 10/3/12, effective 12/1/12]

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◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 July 1, 2009, effective date of amendments to 78.27(2)*"d"* delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 May 11, 2011, effective date of 78.34(5)*"d,"* 78.38(5)*"h,"* 78.41(2)*"g,"* 78.43(3)*"d,"* and 78.52(5)*"a"* delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

3. The rates a provider may charge are subject to limits established at 79.1(2).

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/13 plus 10%. Air ambulance: Fee schedule in effect 6/30/13 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or $1.45 per 15-minute unit, $23.24 per half day, $46.26 per full day, or $69.37 per extended day if no Veterans Administration contract. Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, $1.94 per 15-minute unit, $30.96 per half day, $61.80 per full day, or $78.80 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: $52.04. Ongoing monthly fee: $40.47.
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: $323.26. Initial one-time fee: $52.04. Ongoing monthly fee: $40.47.

Provider category	Basis of reimbursement	Upper limit
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%. For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $5.20 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $87.12 per visit. For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $87.12 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed $311.97 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed $311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed $311.97 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $8.87 per 15-minute unit, not to exceed $311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $4.73 per 15-minute unit, not to exceed $311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed $311.97 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $8.87 per 15-minute unit, not to exceed $311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $4.73 per 15-minute unit, not to exceed $311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed $311.97 per day.

Provider category	Basis of reimbursement	Upper limit
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed $311.97 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $4.05 per 15-minute unit.

Provider category	Basis of reimbursement	Upper limit
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: $1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: $5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: $6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $8.67 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: $115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $1.87 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $5.30 per 15-minute unit, not to exceed $122.62 per day.

Provider category	Basis of reimbursement	Upper limit
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $5.30 per 15-minute unit, not to exceed $122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, $3.54 per 15-minute unit, not to exceed $82.53 per day.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $11.34 per 15-minute unit.
Group	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $11.33 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1)*"d."*	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: $9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $955.00 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: $9.19 per 15-minute unit. Maximum of 104 units per 12 months.

Provider category	Basis of reimbursement	Upper limit
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: $9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. $5.20 per 15-minute unit for personal care. $1.63 per 15-minute unit for services in an enclave setting. $3,029.62 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, $6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $11.34 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, $50.66 per day or $13.87 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $3.45 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.

Provider category	Basis of reimbursement	Upper limit
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: $3.47 per 15-minute unit or $67.55 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, $6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $9.19 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $24.60 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	$25.75 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24)*"d"*	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24)*"d"*	Effective 7/1/13: $11.68 per 15-minute unit, not to exceed $6,083 per month, or $200 per day.
3. Day habilitation	See 79.1(24)*"d"*	Effective 7/1/13: $3.30 per 15-minute unit or $64.29 per day.

Provider category	Basis of reimbursement	Upper limit
4. Prevocational habilitation	See 79.1(24)*"d"*	Effective 7/1/13: $13.47 per hour or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	See 79.1(24)*"d"*	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24)*"d"*	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	See 79.1(24)*"d"*	Effective 7/1/13: Maximum of $8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24)*"d"*	Effective 7/1/13: $1.55 per 15-minute unit for services in an enclave setting; $4.95 per 15-minute unit for personal care; and $8.75 per 15-minute unit for all other services. Total not to exceed $2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.

Provider category	Basis of reimbursement	Upper limit
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
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. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Qualified primary care services furnished in 2013 or 2014	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c"*
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)*"n."*

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)*"y."* Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit

pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical

education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)*"y"* and the rural hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. Rescinded IAB 10/30/13, effective 1/1/14.

c. Payment for primary care services furnished in 2013 or 2014. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to this paragraph (79.1(7)*"c"*).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)*"c"*), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty

designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)*"c"*), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(A)(1).

(5) Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the vaccines for children program in calendar years 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the vaccines for children program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)*"c,"* whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)*"i"*; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)*"i."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8)*"i."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8)*"i."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)*"d,"* whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)*"i"*; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)*"i."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"k,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"j."*

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"j."*

(3) The submitted charge, representing the provider's usual and customary charge for the drug.

d. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"k,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"j."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

e. No payment shall be made for sales tax.

f. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

g. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)*"c,"* whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8)*"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

h. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

i. Rescinded IAB 6/11/14, effective 8/1/14.

j. The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.

k. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no

current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

l. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

m. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

n. Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis

to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to

the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals

during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding

whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

Indicator	Item, Code, or Service	OPPS Payment Status
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are

allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation

cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

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.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24)*"b"* and *"c."* Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24)*"d."* All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. A 15-minute unit for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert

the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24)*"b"*(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after July 1, 2013.

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)*"b,"* the Iowa Plan for Behavioral Health contractor shall reduce the

provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services on or after January 1, 2014, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)*"b,"* the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

79.1(25) *Reimbursement for community mental health centers 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.

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be

received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension .xls or .xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"*(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.

2. Penalties.

3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice.

The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14]

441—79.2(249A) Sanctions.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of the matter in dispute between the person and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to a person.

79.2(2) *Grounds for sanctions.* The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, sanctioned, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

(4) Suspension of payments in whole or in part.

(5) Prior authorization of services.

(6) Review of claims prior to payment.

b. The withholding of payments or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments and interest charged may be withheld from future payments to the provider without imposing a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory when a person pleads guilty or nolo contendere to, or is convicted of, any crime punishable by a term of imprisonment greater than five years, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty. Termination is also mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the person's passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, termination from the medical assistance program is mandatory when, in the case of a natural person, the person has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry or, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned by a person who has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry.

79.2(4) *Imposition and extent of sanction.*

a. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

(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 (technical assistance).
(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.

b. A ground for sanction may precede enrollment in the medical assistance program, the person's passing of a background check, or similar prior approval for participation as a provider in the medical assistance program. The mere fact of an enrollment, a person's passing of a background check, or another approval is not relevant to the sanction decision.

c. Upon certification from the U.S. Department of Justice or the Iowa department of justice that a provider has failed to respond to a civil investigative demand in a timely manner as set forth in Iowa Code chapter 685 and the demand itself, the department shall immediately suspend the provider from participation and suspend all payments to the provider. The suspension and payment suspension shall end upon certification that the provider has responded to the demand in full.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) *Notice of violation.*

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of any sanction, overpayment, civil monetary penalty, or other adverse action, 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.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. *Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:
1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:
1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:
1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:
1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:
1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:
1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.

(9) Clinic services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.

3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:

1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:
1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:
1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:
1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.

6. Invoices or receipts.

7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.

2. Initial physical therapy certification, recertifications, and treatment plans.

3. Treatment notes and forms.

4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.

2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).

2. Documentation of hearing aid evaluation and selection (Form 470-0828).

3. Waiver of informed consent.

4. Prior authorization documentation.

5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.

2. Individual treatment plan.

3. Service or office notes or narratives.

(40) Health home services:

1. Comprehensive care management plan.

2. Care coordination and health promotion plan.

3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.

4. Documentation of member and family support (including authorized representatives).

5. Documentation of referral to community and social support services, if relevant.

(41) Services of public health agencies:

1. Service or office notes or narratives.

2. Immunization records.

3. Results of communicable disease testing.

e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0711C**, IAB 5/1/13, effective 7/1/13]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, "good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0712C**, IAB 5/1/13, effective 7/1/13; **ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. *Council.* The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically

using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Medical assistance funds are incorrectly paid whenever a person who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)*"a"*(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control any other; or

(5) The ability of a third party to control any member of the affiliation.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the "limited," "moderate," or "high" categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the "limited" risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from "limited" or "moderate" to "high" when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state's Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,

4. A nurse practitioner, or

5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration Web site at www.imeincentives.com. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation Web site.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[**ARC 9254B**, IAB 12/1/10, effective 1/1/11; **ARC 9531B**, IAB 6/1/11, effective 5/12/11; **ARC 0824C**, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded **ARC 1056C**, IAB 10/2/13, effective 11/6/13.

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◊ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

7 July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7)*"b"* (ARC 9959B, IAB 1/11/12).

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-92, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

b. All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise shall submit:

(1) Form 470-4707, Medicare Crossover Invoice (Institutional), along with the Explanation of Medicare Benefits (EOMB) for institutional services.

(2) Form 470-4708, Medicare Crossover Invoice (Professional), along with the Explanation of Medicare Benefits (EOMB) for professional services.

80.2(3) Providers shall purchase or copy their supplies of forms CMS-1450 and CMS-1500 for use in billing.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9724B**, IAB 9/7/11, effective 9/1/11; **ARC 9889B**, IAB 11/30/11, effective 1/4/12]

441—80.3(249A) Payment from other sources.

80.3(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) *Third-party liability.* When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

(1) Prenatal care,

(2) Preventive pediatric services, and

(3) All services provided to a person for whom there is court-ordered medical support.

b. Otherwise authorized by the department.

80.3(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

This rule is intended to implement Iowa Code chapter 249A.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.4(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by the Iowa Medicaid enterprise within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.4(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

a. The department shall issue the Medical Assistance Eligibility Card:

(1) When the member's eligibility is initially determined.

(2) Annually thereafter.

(3) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) *Third-party liability.* Rescinded IAB 2/11/09, effective 3/18/09.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

441—80.7(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care

organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.7(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.7(2) *Agreement form.*

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

80.7(3) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

[**ARC 1070C**, IAB 10/2/13, effective 10/1/13]

These rules are intended to implement Iowa Code section 249A.4.

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◊ Two or more ARCs

CHAPTER 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.

"Direct care component" means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants,

rehabilitation nurses, and contracted nursing services. "Direct care component" also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

"Discharged resident" means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

"Facility-based nurse aide training program" means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Facility cost report period case-mix index" is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

"Facilitywide average case-mix index" is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

"Informed consent" means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Laboratory experience" means practicing care-giving skills prior to contact in the clinical setting.

"Level I review" means screening to identify persons suspected of having mental illness or mental retardation as defined in 42 CFR 483.102 as amended to October 1, 2010.

"Level II review" means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

"Major renovations" means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds $1.5 million. The $1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility's financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the $1.5 million threshold.

"Medicaid average case-mix index" is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

"Minimum data set" or *"MDS"* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility's case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16)*"b,"* for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16)*"c"* and *"e,"* the excess payment allowance pursuant to paragraph 81.6(16)*"d,"* and the limits on reimbursement components pursuant to paragraph 81.6(16)*"f."* MDS is described in subrule 81.13(9).

"Minimum food, shelter, clothing, supervision, physical or mental health care, or other care" means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

"Mistreatment" means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation

or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

"New construction" means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

"Non-direct care component" means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

"Non-facility-based nurse aide training program" means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

"Nurse aide" means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

"Nurse aide registry" means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

"Nurse aide training and competency evaluation programs (NATCEP)" are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

"PASRR" means the preadmission screening and annual review of persons with mental illness, mental retardation or a related condition who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to October 1, 2010.

"Patient-day-weighted median cost" means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

"Physical abuse" means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

"Poor performing facility (PPF)" is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)*"o."*

"Primary instructor" means a registered nurse responsible for teaching a state-approved nurse aide training course.

"Program coordinator" means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

"Rate determination letter" means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility's Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

"Skills performance record" means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.

3. Space to note satisfactory or unsatisfactory performance.

4. The signature of the instructor supervising the performance.

"Special population nursing facility" refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 21 and under and require the skilled level of care.

2. Seventy percent of the residents served require the skilled level of care for neurological disorders.

"Terminated from the Medicare or Medicaid program" means a facility has lost the final appeal to which it is entitled.

"Testing entity" means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* and 249A.4.

[**ARC 8445B**, IAB 1/13/10, effective 12/11/09; **ARC 9726B**, IAB 9/7/11, effective 9/1/11; **ARC 9888B**, IAB 11/30/11, effective 1/4/12; **ARC 0994C**, IAB 9/4/13, effective 11/1/13]

441—81.2 Rescinded, effective 11/21/79.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) *Preadmission review.* The IME medical services unit shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person's care. When a Level I review identifies evidence for the presence of mental illness or mental retardation, the department's contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness, mental retardation, or related conditions is normally not needed.

(1) The person's attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person's physical condition, and the person is not a danger to self or others. If the person's nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person's illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person's caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with mental retardation or a related condition.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and

2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and

3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and

4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine whether the person seeking admission:

(1) Needs specialized services for mental illness as defined in paragraph 81.13(14)*"b,"* using the procedures set forth in 42 CFR 483.134 as amended to October 1, 2010; or

(2) Needs specialized services for mental retardation or a related condition as defined in paragraph 81.13(14)*"c,"* using the procedures set forth in 42 CFR 483.136 as amended to October 1, 2010.

c. The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health and disability services that the person's treatment needs will be or are being met.

81.3(4) *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a"* and 249A.4.

[**ARC 8445B**, IAB 1/13/10, effective 12/11/09; **ARC 9726B**, IAB 9/7/11, effective 9/1/11; **ARC 9888B**, IAB 11/30/11, effective 1/4/12]

441—81.4(249A) Arrangements with residents.

81.4(1) *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

81.4(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5)*"c."*) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged

to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

441—81.5(249A) Discharge and transfer. (See subrules 81.13(2)*"a"* and 81.13(6)*"c."*)

81.5(1) *Notice.* When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

81.5(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.
d. Nursing care plan.
e. Physician's orders for care.
f. The resident's personal records.
g. When applicable, the personal needs fund record.
h. Resident care review team assessment.

81.5(5) *Unused client participation.* When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to

the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3)*"e."*

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

81.6(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on

amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed $94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

(4) Rescinded IAB 9/8/10, effective 8/12/10.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) *Census of public assistance recipients.* Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

81.6(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or X-ray services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred

compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3)*"e."*

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11)*"h"*(4) to 81.6(11)*"h"*(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph *"a,"* plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph *"a,"* plus the landlord's other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21)*"a."*

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)*"c."* The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

81.6(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days' prior notice. A

transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) *Amended reports.* The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) *Payment to new facility.* The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to

paragraph 81.6(16)*"c."* After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility's average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility's first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

81.6(15) *Payment to new owner.* An existing facility with a new owner shall continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility's fiscal year will end.

81.6(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph *"a"*) determines the per diem direct care and non-direct care component costs. The second step (paragraph *"b"*) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph *"c"*) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph *"d"*) calculates the potential excess payment allowance. The fifth step (paragraph *"e"*) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph *"h,"* that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph *"h,"* in step six (paragraph *"f"*). The seventh step (paragraph *"g"*) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)*"a."* In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16)*"b"* times

the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed $8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)*"a."* In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)*"a."* In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph *"d,"* not to exceed the rate component limits determined by the methodology in paragraph *"f."*

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph *"d."*

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph *"d"* and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph *"h."*

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs *"d"* and *"e,"* in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph *"d"* times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the "payment period") for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or

special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification

Standard	Measurement Period	Value	Source
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts..	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard
Subcategory: Staffing			
Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities. Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

Standard	Measurement Period	Value	Source
Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.	Calendar year ending December 31 of the payment period	5 points	Self-certification
Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility. To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

Score	Amount of Add-on Payment
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)*"g"*; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph *"f."*

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph *"f."* The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or

2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility's most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph *"g,"* subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.

2. Services shall be provided on the direct site of the facility but not as a nursing facility service.

3. Services shall meet all federal and state requirements for Medicaid reimbursement.

4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.

2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.

3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).

4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the

request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph *"f."*

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph *"f."* The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated

effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) *Cost report documentation.* All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) *Inflation factor.* The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) *Case-mix index calculation.*

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph *"a."* From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) *Medicare crossover claims for nursing facility services.*

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse nursing facilities for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year or by a mutually acceptable schedule consistent with Medicare interim payment schedules.

d. Application of savings. Effective May 1, 2003, savings in Medicaid reimbursements attributable to the limits on nursing facility crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

81.6(21) *Nursing facility quality assurance payments.*

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of $10 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. *Effective date.* Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. *End date.* If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 249L.

[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8445B**, IAB 1/13/10, effective 12/11/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8995B**, IAB 8/11/10, effective 9/15/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 0994C**, IAB 9/4/13, effective 11/1/13]

441—81.7(249A) Continued review.

81.7(1) *Level of care.* The IME medical services unit shall review Medicaid members' need of continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1).

81.7(2) *PASRR.* Within the fourth calendar quarter after the previous review, the PASRR contractor shall review all nursing facility residents admitted pursuant to paragraph 81.3(3)*"c"* to determine:

a. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility, and

b. Whether the resident needs specialized services for mental illness or mental retardation as described in paragraph 81.3(3)*"b."*

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.

[**ARC 8445B**, IAB 1/13/10, effective 12/11/09; **ARC 9726B**, IAB 9/7/11, effective 9/1/11; **ARC 9888B**, IAB 11/30/11, effective 1/4/12]

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) *Retention.* Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.10(249A) Payment procedures.

81.10(1) *Method of payment.* Except for Medicaid accountability measures payment established in paragraph 81.6(16)*"g,"* facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) *Authorization of payment.* The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

81.10(4) *Periods authorized for payment.*

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Effective December 1, 2009, payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities, which shall be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16)*"f"*(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.

81.10(5) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)*"a"*(4), medical supplies except for those listed in 441—paragraph 78.10(4)*"b,"* oxygen except under circumstances specified in 441—paragraph 78.10(2)*"a,"* and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician except for those specified in 441—paragraph 78.1(2)*"f."*

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by 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.

(6) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)*"a"*(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident's family, or friends may pay to hold the resident's bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident's family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 80 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;

- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

81.10(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

81.10(7) *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 8995B**, IAB 8/11/10, effective 9/15/10; **ARC 0714C**, IAB 5/1/13, effective 7/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14]

441—81.11(249A) Billing procedures.

81.11(1) *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039.

a. When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The white copy of the form shall be signed and returned to the Iowa Medicaid enterprise as a claim for the next month. If the claim is submitted electronically, the facility will receive remittance advice of the claims paid.

b. When there has been a new admission or a discharge, the facility shall submit Form 470-0039 with the changes noted. When a change is necessary to adjust a previously paid claim, the facility shall submit Form 470-0040, Credit/Adjustment Request. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

k. Rescinded IAB 12/6/95, effective 2/1/96.

81.13(2) *Medicaid provider agreements.* The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. Rescinded IAB 2/3/93, effective 4/1/93.

b. Rescinded IAB 2/3/93, effective 4/1/93.

c. Rescinded IAB 2/3/93, effective 4/1/93.

d. Rescinded IAB 2/3/93, effective 4/1/93.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

f. Rescinded IAB 2/3/93, effective 4/1/93.

81.13(3) *Distinct part requirement.* All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) *Civil rights.* The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) *Resident rights.* The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of $50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed $50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches $200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. *Free choice.* The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

f. *Grievances.* A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. *Examination of survey results.* A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. *Work.* The resident has the right to:

(1) Refuse to perform services for the facility.

(2) Perform services for the facility if the resident chooses, when:

1. The facility has documented the need or desire for work in the plan of care.

2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

3. Compensation for paid services is at or above prevailing rates.

4. The resident agrees to the work arrangement described in the plan of care.

5. Rescinded IAB 3/4/92, effective 4/8/92.

i. *Mail.* The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

j. *Access and visitation rights.*

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.
2. Any representative of the state.
3. The resident's individual physician.
4. The state long-term care ombudsman.
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
6. The agency responsible for the protection and advocacy system for mentally ill individuals.
7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.
8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. *Married couples.* The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. *Self-administration of drugs.* An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. *Refusal of certain transfers.*

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. *Advance directives.*

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

81.13(6) *Admission, transfer and discharge rights.*

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall including the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)*"a"*(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)*"a,"* and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or

potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) *Resident behavior and facility practices.*

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

*(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) *Quality of life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) *Resident assessment.* The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.
2. Customary routine.
3. Cognitive patterns.
4. Communication.
5. Vision.
6. Mood and behavior patterns.
7. Psychosocial well-being.
8. Physical functioning and structural problems.
9. Continence.
10. Disease diagnoses and health conditions.
11. Dental and nutritional status.
12. Skin condition.
13. Activity pursuit.
14. Medications.
15. Special treatments and procedures.
16. Discharge potential.
17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
18. Documentation of participation in assessment.
19. Additional specification relating to resident status as required in Section S of the MDS.

(3) Frequency. Assessments shall be conducted:

1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.

3. In no case less often than once every 12 months.

(4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.

(5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.

(6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(7) Automated data processing requirement.

1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.

- Admission assessment.
- Annual assessment updates.
- Significant change in status assessments.
- Quarterly review assessments.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, if there is no admission assessment.

2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure

accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph *"b,"* subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph *"b,"* subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Preadmission screening for mentally ill individuals and individuals with mental retardation. Rescinded IAB 9/7/11, effective 9/1/11.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) *Quality of care.* Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. *Mental and psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. *Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasalpharyngeal ulcers and to restore, if possible, normal eating skills.

h. *Accidents.* The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. *Nutrition.* Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. *Hydration.* The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. *Special needs.* The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. *Unnecessary drugs.*

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or

4. Without adequate indications for its use; or

5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

(1) It is free of significant medication error rates of 5 percent or greater.

(2) Residents are free of any significant medication errors.

81.13(11) *Nursing services.* The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph *"c,"* licensed nurses.

2. Other nursing personnel.

(2) Except when waived under paragraph *"c,"* the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

(1) Except when waived under paragraph *"c,"* the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph *"c,"* the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph *"b,"* or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph *"a,"* if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph *"c"* is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) *Dietary services.* The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) *Physician services.* A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph *"c"* below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph *"e,"* all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) *Specialized services.* When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

(1) Provide the required services; or

(2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) May be provided only by a specialized licensed or certified practitioner;

(5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

(6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available through the Iowa plan for behavioral health and for which the member meets eligibility criteria.

c. Specialized services for mental retardation or a related condition. "Specialized services for mental retardation or a related condition" means services that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) Must be supervised by a qualified mental retardation professional; and

(5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) *Dental services.* The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

(1) Routine dental services to the extent covered under the state plan.

(2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) *Pharmacy services.* The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. *Procedures.* A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. *Service consultation.* The facility shall employ or obtain the services of a licensed pharmacist who:

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. *Drug regimen review.*

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. *Labeling of drugs and biologicals.* Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. *Storage of drugs and biologicals.*

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. *Consultant pharmacists.* When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) *Infection control.* The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. Infection control program. The facility shall establish an infection control program under which it:

(1) Investigates, controls and prevents infections in the facility.

(2) Decides what procedures, such as isolation, should be applied to an individual resident.

(3) Maintains a record of incidents and corrective actions related to infections.

b. Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) *Physical environment.* The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. Life safety from fire. Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. Emergency power.

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph *"d,"* subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

(2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.

(3) Equip corridors with firmly secured handrails on each side.

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) *Administration.* A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.

2. Responsible for management of the facility.

e. Required training of nurse aides.

(1) Definitions.

"Licensed health professional" means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

"Nurse aide" means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.

2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;

2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or

3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or

2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility shall:

1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

l. Clinical records.

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

(2) Clinical records shall be retained for:

1. The period of time required by state law.

2. Five years from the date of discharge when there is no requirement in state law.

3. For a minor, three years after a resident reaches legal age under state law.

(3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

1. Transfer to another health care institution.

2. Law.

3. Third-party payment contract.

4. The resident.

(5) The clinical record shall contain:

1. Sufficient information to identify the resident.

2. A record of the resident's assessments.

3. The plan of care and services provided.

4. The results of any preadmission screening conducted by the state.

5. Progress notes.

m. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

n. Transfer agreement.

(1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:

1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.

2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

o. Quality assessment and assurance.

(1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

(2) The quality assessment and assurance committee:

1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.

2. Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

p. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.

(2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.

2. The officers, directors, agents, or managing employees.

3. The corporation, association, or other company responsible for the management of the facility.

4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

[**ARC 8445B**, IAB 1/13/10, effective 12/11/09; **ARC 9726B**, IAB 9/7/11, effective 9/1/11; **ARC 9888B**, IAB 11/30/11, effective 1/4/12]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) *Audit of proper billing and handling of patient funds.*

a. Field auditors of the department of inspections and appeals, or representatives of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph *"d,"* the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a"* and 249A.4.

441—81.15(249A) Nurse aide training and testing programs. Rescinded IAB 12/9/92, effective 2/1/93.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

a. At least 60 hours were substituted for 75 hours; and

b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or

c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or

d. The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989; or

e. The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered.

81.16(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19)*"e"* and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2)*"f,"* the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than $5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

(3) Rescinded IAB 10/7/98, effective 12/1/98.

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2)*"b"*(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2)*"b"*(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and testing programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.

2. Infection control.

3. Safety and emergency procedures including the Heimlich maneuver.

4. Promoting residents' independence.

5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.

2. Measuring and recording height and weight.

3. Caring for the residents' environment.

4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.

5. Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to:

1. Bathing.
2. Grooming, including mouth care.
3. Dressing.
4. Toileting.
5. Assisting with eating and hydration.
6. Proper feeding techniques.
7. Skin care.
8. Transfers, positioning, and turning.

(4) Mental health and social service needs:

1. Modifying aide's behavior in response to residents' behavior.
2. Awareness of developmental tasks associated with the aging process.
3. How to respond to resident behavior.
4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
5. Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
2. Communicating with cognitively impaired residents.
3. Understanding the behavior of cognitively impaired residents.
4. Appropriate responses to the behavior of cognitively impaired residents.
5. Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

1. Training the resident in self-care according to the resident's ability.
2. Use of assistive devices in transferring, ambulation, eating and dressing.
3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.
6. Care and use of prosthetic and orthotic devices.

(7) Residents' rights:

1. Providing privacy and maintenance of confidentiality.
2. Promoting the residents' rights to make personal choices to accommodate their needs.
3. Giving assistance in resolving grievances and disputes.
4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
5. Maintaining care and security of residents' personal possessions.
6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
7. Avoiding the need for restraints in accordance with current professional standards.

c. Prohibition of charges.

(1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the aides for the course, books, and tests.

2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.

3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.

d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:

(1) Notify the department of inspections and appeals:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.

2. When a facility or other training entity will no longer be offering nurse aide training courses.

3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) *Nurse aide competency evaluation.* A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

(1) Written or oral examinations. The competency evaluation shall:

1. Allow an aide to choose between a written and oral examination.

2. Address each of the course requirements listed in 81.16(3)*"b."*

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3)*"b"*(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3)*"c."*

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) *Registry of nurse aides.*

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5)*"c."*

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5)*"c"*(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) *Hearing.* When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) *Appeals.* Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.

441—81.17(249A) Termination procedures. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.18(249A) Sanctions.

81.18(1) *Penalty for falsification of a resident assessment.* An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than $100 or more than $1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than $500 nor more than $5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

(1) The number of assessments willingly and knowingly falsified.

(2) The history of the individual relative to previous assessment falsifications.

(3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.

(4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) *Use of independent assessors.* If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed $2,000.

81.18(4) *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95.

This rule is intended to implement Iowa Code section 249A.4.

441—81.19(249A) Criteria related to the specific sanctions. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) *Out-of-state providers.* Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)*"f"*(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)*"f"*(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident's health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)*"e"*(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident's health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

81.20(3) Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

81.20(4) Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8995B**, IAB 8/11/10, effective 9/15/10]

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph *"i."*

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) *Maximum client participation.* A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) *Beginning date of payment.* When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning date of eligibility is given on the Facility Card, Form 470-0371. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month

shall receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

441—81.24 to **81.30** Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may by used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

"CMS" means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

"Deficiency" means a nursing facility's failure to meet a participation requirement.

"Department" means the Iowa department of human services.

"Immediate jeopardy" means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

"New admission" means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

"Noncompliance" means any deficiency that causes a facility to not be in substantial compliance.

"Plan of correction" means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

"Standard survey" means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

"Substandard quality of care" means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

"Substantial compliance" means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

"Temporary management" means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation.

441—81.32(249A) General provisions.

81.32(1) *Purpose of remedies.* The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) *Basis for imposition and duration of remedies.* The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) *Number of remedies.* The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) *Plan of correction requirement.*

a. Except as specified in paragraph *"b,"* regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) *Disagreement regarding remedies.* If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) *Notification requirements.*

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

(1) Nature of the noncompliance.

(2) Which remedy is imposed.

(3) Effective date of the remedy.

(4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) *Informal dispute resolution.*

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from

the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) *Initial assessment.* In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) *Determining seriousness of deficiencies.* To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

(1) No actual harm with a potential for minimal harm.

(2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.

(3) Actual harm that is not immediate jeopardy.

(4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

(1) Are isolated.

(2) Constitute a pattern.

(3) Are widespread.

81.33(3) *Other factors which may be considered in choosing a remedy within a remedy category.* Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) *Categories of remedies.* Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) *Application of remedies.* After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3)*"a,"*81.35(4)*"a,"* and 81.35(5)*"a,"* for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3)*"b,"*81.35(4)*"b,"* and 81.35(5)*"b,"* as applicable.

81.35(3) *Category 1.*

a. Category 1 remedies include the following:

(1) Directed plan of correction.

(2) State monitoring.

(3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

(1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or

(2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) *Category 2.*

a. Category 2 remedies include the following:

(1) Denial of payment for new admissions.

(2) Civil money penalties of $50 to $3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

(1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or

(2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) *Category 3.*

a. Category 3 remedies include the following:

(1) Temporary management.

(2) Immediate termination.

(3) Civil money penalties of $3,050 to $10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

(1) Temporary management.

(2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of $3,050 to $10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) *Plan of correction.*

a. Except as specified in paragraph *"b,"* each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

(1) Which remedies are applied.

(2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) *Appeal of a determination of noncompliance.*

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) *Terminate agreement or appoint temporary manager.* If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) *Other remedies.* The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) *Notification of CMS.* In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) *Transfer of residents.* The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) *Notification of physicians and state board.* If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) *Termination of agreement or limitation of participation.* If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;

b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and

c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) *Termination.* If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) *Denial of payment.* Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) *Failure to comply.* The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) *General.* If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) *Repeated noncompliance.* For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) *Standard surveys to which this provision applies.* Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) *Program participation.*

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) *Compliance.* Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

(1) Alleges correction of the deficiencies cited in the most recent standard survey; or

(2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) *Qualifications.* The temporary manager must:

a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.

b. Not have been found guilty of misconduct by any licensing board or professional society in any state.

c. Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.

d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) *Payment of salary.* The temporary manager's salary:

a. Is paid directly by the facility while the temporary manager is assigned to that facility.

b. Shall be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.

(2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.

(3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.

c. May exceed the amount specified in paragraph *"b"* if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) *Failure to relinquish authority to temporary management.*

a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) *Duration of temporary management.* Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) *Optional denial of payment.* Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) *Required denial of payment.* Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) *Resumption of payments.* Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) *Resumption of payments.* No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) *Restriction.* No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) *CMS option to deny all payment.* If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) *Resumption of payment.* When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) *State monitor.* A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) *Use of state monitor.* A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) *Discontinuance of state monitor.* State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) *Required training.* The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

a. The facility has a pattern of deficiencies that indicate noncompliance; and

b. Education is likely to correct the deficiencies.

81.44(2) *Action following training.* After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) *Payment.* The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) *Closure during an emergency.* In an emergency, the department and the department of inspections and appeals have the authority to:

a. Transfer Medicaid and Medicare residents to another facility; or

b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) *Required transfer in immediate jeopardy situations.* When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) *All other situations.* Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) *When facility requests a hearing.*

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) *When facility does not request a hearing.* If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

a. Achieves substantial compliance; or

b. Is terminated.

81.47(3) *When facility waives a hearing.* If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

a. Achieves substantial compliance; or

b. Is terminated.

81.47(4) *Accrual and computation of penalties.* Accrual and computation of penalties for a facility that:

a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);

b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) *Collection.* The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) *Waiver of a hearing.* The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) *Reduction of penalty amount.*

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) *Amount of penalty.* The penalties are within the following ranges, set at $50 increments:

a. Upper range—$3,050 to $10,000. Penalties in the range of $3,050 to $10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4)*"b."*

b. Lower range—$50 to $3,000. Penalties in the range of $50 to $3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) *Basis for penalty amount.* The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) *Decreased penalty amounts.* Except as specified in 81.50(4)*"b,"* if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) *Increased penalty amounts.*

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) *Review of the penalty.* When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

a. Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) *Factors affecting the amount of penalty.* In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

a. The facility's history of noncompliance, including repeated deficiencies.

b. The facility's financial condition.

c. The factors specified in rule 441—81.33(249A).

d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) *Authority to settle penalties.* The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) *When penalty begins to accrue.* The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) *Duration of penalty.* The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;

b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or

c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) *Penalty due.* The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) *Notice after facility achieves compliance.* When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

a. The amount of penalty per day;

b. The number of days involved;

c. The total amount due;

d. The due date of the penalty; and

e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) *Notice to terminated facility.* In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

a. Final administrative decision is made;

b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or

c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) *Accrual of penalties when there is no immediate jeopardy.*

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph *"a,"* if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) *Accrual of penalties when there is immediate jeopardy.*

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) *Documenting substantial compliance.*

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) *When payments are due.*

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

(1) The facility achieves substantial compliance before the final administrative decision; or

(2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

(1) The facility achieves substantial compliance before the hearing request was due; or

(2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

(1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or

(2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

(1) The final administrative decision is made before the facility came into compliance;

(2) The facility did not file a timely hearing request before it came into substantial compliance; or

(3) The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

(1) The final administrative decision was made;

(2) The time for requesting a hearing has expired and the facility did not request a hearing; or

(3) The facility waived its right to a hearing.

f. In the cases specified in paragraph *"d,"* the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) *Deduction of penalty from amount owed.* The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) *Interest.* Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

81.52(4) *Penalties collected by the department.* Rescinded IAB 3/9/11, effective 4/1/11.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Payment for the cost of relocating residents to other facilities;

2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;

3. Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and

4. Funding of projects to improve the quality of life or quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) *Criteria.*

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

(1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;

(2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and

(3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)*"a"* are not met.

81.54(2) *Cessation of payments.* If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)*"a"* are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) *Period of continued payments.* If the conditions in 81.54(1)*"a"* are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) *Failure to achieve substantial compliance.* If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) *Disagreement over whether facility has met requirements.*

a. The department of inspections and appeals' finding of noncompliance takes precedence when:

(1) CMS finds the facility is in substantial compliance with the participation requirements; and

(2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS's findings of noncompliance take precedence when:

(1) CMS finds that a facility has not achieved substantial compliance; and

(2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS's survey findings take precedence, CMS may:

(1) Impose any of the alternative remedies specified in rule 441—81.34(249A);

(2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and

(3) Stop federal financial participation to the department for a nursing facility.

81.55(2) *Disagreement over decision to terminate.*

a. CMS's decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

a. A facility is not in substantial compliance; and

b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) *Facility in compliance.* If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) *Effect of termination.* Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) *Basis of termination.*

a. A facility's provider agreement may be terminated if a facility:

(1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

(1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

(2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)*"a."*

81.57(3) *Notice of termination.* Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]
[Prior to 2/11/87, Human Services[498]]

441—82.1(249A) Definition.

"Department" means the Iowa department of human services.

This rule is intended to implement Iowa Code section 249A.12.

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as a hospital, nursing facility, or an intermediate care facility for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

82.2(1) *Governing body and management.*

a. *Governing body.* The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

(1) Exercise general policy, budget, and operating direction over the facility.

(2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.

(3) Appoint the administrator of the facility.

b. *Compliance with federal, state, and local laws.* The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. *Client records.*

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients' health care, active treatment, social information, and protection of the client's rights.

(2) The facility shall keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client's record.

d. *Services provided under agreements with outside sources.*

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs *"a"* to *"g," "j,"* and *"k."*

e. *Disclosure of ownership.* The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) *Client protections.*

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) *Facility staffing.*

a. Qualified intellectual disability professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3)*"b"*(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)*"b"*(5) are not required except for qualified intellectual disability professionals who must meet the requirements set forth in 82.2(3)*"a."*

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly intellectually disabled clients, clients with severe physical disabilities, or clients who are

aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately intellectually disabled clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild intellectual disability, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) *Active treatment services.*

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4)*"c"*(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, the client's parents (if the

client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4)*"c"*(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.
4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
5. The inappropriate client behaviors, if applicable.
6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.
2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.
3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.
4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.
5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.
6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.
2. Is regressing or losing skills already gained.
3. Is failing to progress toward identified objectives after reasonable efforts have been made.
4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4)*"c."*

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4)*"f"*(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) *Client behavior and facility practices.*

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.

4. Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients shall participate in the formulation of these policies and procedures.

(3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

b. Management of inappropriate client behavior.

(1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5)*"a."* These procedures shall:

1. Specify all facility-approved interventions to manage inappropriate client behavior.

2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.

3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

(2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4)*"c"*(4) and (5).

(5) Standing or as-needed programs to control inappropriate behavior are not permitted.

c. Time-out rooms.

(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

1. The placement is a part of an approved systematic time-out program as required by 82.2(5)*"b."*

2. The client is under the direct constant visual supervision of designated staff.

3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

(2) Placement of a client in a time-out room shall not exceed one hour.

(3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

(4) A record of time-out activities shall be kept.

d. Physical restraints.

(1) The facility may employ physical restraint only:

1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.

3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

(2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.

(3) The facility shall not issue orders for restraint on a standing or as-needed basis.

(4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

(5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

(7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

(1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

(2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

(3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

(4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6)*"j,"* for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) *Health care services.*

a. Physician services.

(1) The facility shall ensure the availability of physician services 24 hours a day.

(2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

(3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.
2. Be by a licensed nurse.
3. Be on a quarterly or more frequent basis depending on client need.
4. Be recorded in the client's record.
5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.
2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.
3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. *Pharmacy services.* The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. *Drug regimen review.*

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. *Drug administration.* The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. *Drug storage and record keeping.*

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6)*"k"*(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. *Drug labeling.*

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. *Laboratory services.*

(1) For purposes of this subrule, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) *Physical environment.*

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

(1) Bedrooms shall:

1. Be rooms that have at least one outside wall.
2. Be equipped with or located near toilet and bathing facilities.
3. Accommodate no more than four clients unless granted a variance under 82.2(7)*"b"*(3).
4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.
5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.

(3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility shall provide each client with:

1. A separate bed of proper size and height for the convenience of the client.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

c. *Storage space in bedroom.* The facility shall provide:

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.

(2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

d. *Client bathrooms.* The facility shall:

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.

(2) Provide for individual privacy in toilets, bathtubs, and showers.

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

e. *Heating and ventilation.*

(1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

f. *Floors.* The facility shall have:

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.

(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

g. *Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. *Emergency plan and procedures.*

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. *Evacuation drills.*

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7)*"i"*(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7)*"i"*(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. *Meal services.*

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8)*"b"*(1)"1."

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. *Menus.*

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. *Dining areas and service.* The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) *Procedures for establishing health care facilities as Title XIX facilities.* All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The department shall transmit an application form and copies of standards to the facility.

d. The facility shall complete its portion of the application form and submit it to the department.

e. The department shall review the application form and forward it to the department of inspections and appeals.

f. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.

k. The department shall review the certification data and:

(1) Transmit the provider agreement as recommended, or

(2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2)*"c."*

82.3(2) *Title XIX provider agreements.* The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for persons with an intellectual disability before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. Terms of the agreement for facilities without deficiencies are as follows:

(1) The provider agreement shall be issued for a period not to exceed 12 months.

(2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.

b. Terms of the agreement for facilities with deficiencies are as follows:

(1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.

(2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

(3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.

c. The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for persons with an intellectual disability in compliance with rules and regulations of the program.

d. The department may at its option extend an agreement with a facility for two months under either of the following conditions:

(1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

(2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.

f. When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) *Appeals of decertification.* A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.4 Rescinded, effective March 1, 1987.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) *Failure to maintain records.* Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) *Submission of reports.* The facility's cost report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than September 30 each year except as described in subrule 82.5(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.5(3)*"c."*

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.5(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.5(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.5(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.5(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as

supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.5(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.5(3)*"c."*

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $1,926 per month plus $20.53 per month per licensed bed capacity for each bed over 60, not to exceed $2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.5(11)*"e"*(4) to 82.5(11)*"e"*(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.5(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare

principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) *Assessed fee.* The fee assessed pursuant to 441—Chapter 36 shall be an allowable cost for cost reporting and audit purposes.

a. For the purpose of implementing the assessment for facilities operated by the state, Medicaid reimbursement rates shall be recalculated effective October 1, 2003, as provided in paragraph *"b."*

b. For purposes of determining rates paid for services rendered after October 1, 2003, each state-operated facility's annual costs for periods before implementation of the assessment shall be increased by an amount equal to 6 percent of the facility's annual revenue for the preceding fiscal year.

82.5(14) *Payment to new facility.* A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14)*"d,"* shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer

Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) *Payment to new owner.* An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) *Payment to existing facilities.* The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14)*"d."*

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

(1) Administrator's salary.
(2) Assistant administrator's salary.
(3) Bookkeeper's salary.
(4) Other accounting and bookkeeping costs.
(5) Other clerical salaries and clerical costs.
(6) Administrative payroll taxes.
(7) Administrative unemployment taxes.
(8) Administrative group insurance.
(9) Administrative general liability and worker's compensation insurance.
(10) Directors' and officers' insurance or salaries.
(11) Management fees.

(12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.

(13) Legal and professional fees.

(14) Dues, conferences and publications.

(15) Postage and telephone.

(16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.

(17) Data processing and bank charges.

(18) Advertising.

(19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

(1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0582C**, IAB 2/6/13, effective 4/1/13; **ARC 0995C**, IAB 9/4/13, effective 11/1/13]

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. Eligibility shall continue as long as a valid need for the care exists.

82.6(4) Rescinded IAB 4/9/97, effective 6/1/97.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.7(249A) Initial approval for ICF/ID care.

82.7(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.7(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department shall:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

82.7(3) *Approval of level of care.* Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit. The IME medical services unit shall review ICF/ID admissions and transfers only when documentation is provided which verifies a referral from targeted case management that includes an approval by the department.

82.7(4) *Appeal rights.* Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—82.8(249A) Determination of need for continued stay. Certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10]

441—82.9(249A) Arrangements with residents.

82.9(1) *Resident care agreement.* The ICF/ID Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.9(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any 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.

82.9(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons

dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.11(249A) Continued stay review. The Iowa Medicaid enterprise (IME) medical services unit shall be responsible for reviews of each resident's need for continuing care in intermediate care facilities for persons with an intellectual disability.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.12(249A) Quality of care review. The Iowa Medicaid enterprise (IME) medical services unit shall carry out the quality of care studies in intermediate care facilities for persons with an intellectual disability.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.13(249A) Records.

82.13(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Payment procedures.

82.14(1) *Method of payment.* Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) *Payment responsibility.* Rescinded IAB 7/11/12, effective 7/1/12.

82.14(3) Rescinded IAB 8/9/89, effective 10/1/89.

82.14(4) *Periods authorized for payment.*

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

82.14(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.15(249A) Billing procedures.

82.15(1) *Claims.* Claims for service 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, Iowa Medicaid Long-Term Care Claim.

a. When payment is made, the facility will receive a copy of Form 470-0039. The white copy of the original shall be returned as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid.

b. When there has been a new admission, a discharge, a correction, or a claim for a reserved bed, the facility shall submit Form 470-0039 with the changes noted. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise.

82.15(2) Reserved.

This rule is intended to implement Iowa Code section 249A.12.

441—82.16(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 Medicaid shall be approved by the county office of the department.

This rule is intended to implement Iowa Code section 249A.12.

441—82.17(249A) Audits.

82.17(1) *Audits of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.17(2) *Auditing of proper billing and handling of patient funds.*

a. 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 that the facility is not receiving payment in excess of the

contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. 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 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph *"d"* the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 0582C**, IAB 2/6/13, effective 4/1/13]

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month shall receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.

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◊ Two or more ARCs

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical

emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$2,765	$950	$3,365

(1) For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than $505 is paid for home and vehicle modification services, the service worker or targeted case manager shall encumber up to $505 per month within the monthly dollar cap allowed for the member until the total amount of the modification is reached within a 12-month period.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)*"a"*(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program

is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-4392, or service plan, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)*"a"* and *"c"* do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)*"c"*(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the service worker or targeted case manager.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) Composition. The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) Role. The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.

2. Available and appropriate services to meet the consumer's needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed

the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

Skilled level of care	Nursing level of care
$2,765	$1,339

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. *Content of service plan.* The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

83.22(3) *Providers—standards.* Rescinded IAB 10/11/06, effective 10/1/06.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility cannot precede the date the case manager signs the case plan.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The department service worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1,840.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with an intellectual disability aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intellectual disability" means a diagnosis of mental retardation which shall be made only when the onset of the person's condition was before the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, published by the American Psychiatric Association.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified intellectual disability professional" means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of mental retardation or, for residential-based supported community living services only, be a person with a related condition as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound mental retardation	Recertification for persons with a diagnosis of mild or unspecified mental retardation
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 through 21 years	• Psychological documentation substantiating diagnosis of mental retardation within three years before the application date, or • Diagnosis of mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation	Psychological documentation substantiating a diagnosis of mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation if the last testing date was (1) more than five years ago for an applicant with a diagnosis of mild or unspecified mental retardation, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound mental retardation	Psychological documentation substantiating a diagnosis of mental retardation made since the member reached 18 years of age	Psychological documentation substantiating a diagnosis of mental retardation every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for annual approval of the

certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

i. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

j. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

k. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service

options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

l. For day habilitation, be 16 years of age or older.

m. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management or services of a department-qualified intellectual disability professional (QIDP) shall have the applicable coordinating staff and other interdisciplinary team members complete Form 470-4694, Case Management Comprehensive Assessment, and identify the applicant's needs and desires as well as the availability and appropriateness of the services.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-4694 or other circumstances beyond the worker's control.

g. At initial enrollment, the service worker, department QIDP, case manager or Medicaid case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent

in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant

care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) *Development.* The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of the consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) *Documentation.* The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) *Approval of plan.* The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. Services must be authorized and entered into ISIS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.
Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.

Child maltreatment syndrome.

Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician;

physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

83.82(2) *Need for services.*

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed

before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed $2,954 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

83.87(4) *Service file.* The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to *d.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to **83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Department" means the Iowa department of human services.

"Guardian" means a guardian appointed in probate court for an adult.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed $692 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S.

Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the consumer.

e. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) *Appeal to county.* Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) *Reconsideration request to IME medical services unit.* Rescinded IAB 9/5/12, effective 11/1/12.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to **83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

"Case manager" means the person designated to provide Medicaid targeted case management services for the consumer.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Consumer" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Deeming" means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

"Department" means the Iowa department of human services.

"Guardian" means a parent of a consumer or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME" means the Iowa Medicaid enterprise.

"IME medical services unit" means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the consumer, the consumer's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer's needs, as designated

by the consumer and the consumer's family, who meet to develop a service plan based on the individualized needs of the consumer.

"ISIS" means the department's individualized services information system.

"Local office" means a department of human services office as described in 441—subrule 1.4(2).

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a written, consumer-centered, outcome-based plan of services developed by the consumer's interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

"Skill development" means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) *Age.* The consumer must be under 18 years of age.

83.122(2) *Diagnosis.* The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant's level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed $1,967 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) *Approval of waiver eligibility.*

a. *Time limit.* Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

b. *Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level-of-care determinations and the consumer's service plan are completed.

83.123(3) *Effective date of eligibility.* The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met;

b. Eligibility and level-of-care determinations have been made; and

c. The service plan has been completed.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) *Eligibility review.* Every 12 months, the local office shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

a. Continuing eligibility factors as specified in rule 441—83.122(249A).

b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

83.125(2) *Continuation of eligibility.* A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) *Payment slot.* When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services shall be denied when the department determines that:

a. The consumer is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6)*"c"* or are not met by the services provided.

83.128(2) *Termination.* A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6)*"c."*

c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services shall apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

[Prior to 7/1/83, Social Services [770] Ch 84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter defines and structures the early and periodic screening, diagnosis and treatment services provided under the Medicaid program to eligible children under the age of 21. As further described in these rules, services include physical and mental health screenings (including hearing and vision), laboratory tests, immunizations, and health education. Services are provided in compliance with federal regulations at Title 42, Part 441, Subpart B, as amended to November 16, 1984.

441—84.1(249A) Definitions.

"Diagnosis" is the determination of the nature of physical or mental disease or abnormality.

"Interperiodic screen" means a screen that occurs between the times stated in the periodicity schedule in 441—subrule 78.18(3).

"Screening" is the use of quick, simple procedures to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive study. These services shall be provided in accordance with reasonable standards of medical and dental practice.

441—84.2(249A) Eligibility. All persons eligible for medical assistance under age 21 are eligible for early and periodic screening, diagnosis, and treatment.

441—84.3(249A) Screening services. Screening may be done by a screening center or other qualified providers. Other qualified providers are physicians, advanced registered nurse practitioners, rural health centers, federally qualified health centers, clinics, and dentists. Screening services shall include all of the following services:

84.3(1) A comprehensive health and developmental history including an assessment of both physical and mental health development. This includes:

a. A developmental assessment.

b. An assessment of nutritional status.

84.3(2) A comprehensive unclothed physical examination. This includes:

a. Physical growth.

b. A physical inspection including ear, nose, mouth, throat, teeth, and all organ systems such as pulmonary, cardiac, and gastrointestinal.

84.3(3) Appropriate immunizations according to age and health history as recommended through the vaccines for children program, except that "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) are not covered 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.

84.3(4) Health education including anticipatory guidance. See 441—subparagraph 78.18(6)*"b"*(1) for a description of the information services.

84.3(5) Hearing and vision screening.

84.3(6) Appropriate laboratory tests. These shall include:

a. Hematocrit or hemoglobin.

b. Rapid urine screening.

c. Lead toxicity screening for all children aged 12 to 72 months.

d. Tuberculin test, when appropriate.

e. Hemoglobinopathy screening.

f. Serology, when appropriate.

84.3(7) Direct dental referral for children over age 12 months.

441—84.4(249A) Referral.

84.4(1) The availability of early and periodic screening shall be discussed with the payee for any Medicaid-eligible child under the age of 21 at the time of application and periodically thereafter in compliance with federal regulations at Title 42, Part 441, Subpart B, as amended to November 16, 1984.

84.4(2) Screening shall be offered to each eligible individual according to the periodicity schedule in 441—subrule 78.18(3) when screening has been accepted, or on at least an annual basis when screening has been rejected. Interperiodic screens may be furnished when medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment.

441—84.5(249A) Follow up. Follow-up services shall be provided when a referral for screening was accepted, but 60 days have elapsed and no screening examination has been performed, and when a screening examination discloses a possible abnormal condition and a referral was made for further diagnosis or treatment and such diagnosis or treatment has not been received within a period of 60 days from the date of the screening examination.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

PREAMBLE

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill. Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill. These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and client eligibility requirements.

DIVISION I
PSYCHIATRIC HOSPITALS

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

(1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.

(2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.

(3) Is accredited as a psychiatric facility by the Joint Commission on the Accreditation of Health Care Organizations or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the division of behavioral, developmental, and protective services for families, adults, and children of the department.

b. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B) or shall be licensed in another state as a hospital, shall be accredited by the Joint

Commission on the Accreditation of Health Care Organizations, the Commission of Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals, and shall meet federal service requirements.

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior approval by the bureau of managed care and clinical services and shall be approved only if special services are not available in Iowa facilities as determined by the division of behavioral, developmental, and protective services for families, adults, and children.

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) *Certification of need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.5(249A) Client participation.

85.5(1) *Before July 2005.* For months before July 2005, the resident shall be liable to pay client participation toward the cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

85.5(2) *July 2005 and after.* Effective with the month of July 2005, the resident shall not be liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) *Fiscal records.*

a. 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, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. *Active treatment.* Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. *Individual plan of care.* An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. *Interdisciplinary team.* The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) *Reimbursement formula.* Acute care in psychiatric hospitals shall be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act and amendments to that Act, Medicare regulations found in the Health Insurance Regulation Manual (HIRM-1), and General Instructions-Health Insurance Manual sections 10, 11, 12 and 15 when applicable.

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9, as amended to December 2, 1996, and 42 CFR 447.250 as amended to September 23, 1992. Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the Iowa Medicaid enterprise provider audits and rate-setting unit for Iowa within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement shall be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions which are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services.

These rules are intended to implement Iowa Code section 249A.4.

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be either:

a. Eligible for one of the coverage groups listed in 441—75.1(249A); or

b. Eligible under the IowaCare program pursuant to 441—Chapter 92.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.*

a. While on inpatient status, a person eligible under a coverage group listed in 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

b. While on inpatient status, a person eligible under the IowaCare program is entitled to the services listed at 441—92.8(249A,81GA,ch167).

441—85.9 to **85.20** Reserved.

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

441—85.21(249A) Conditions for participation. Psychiatric medical institutions for children shall be issued a license by the department of inspections and appeals under Iowa Code chapter 135H and shall hold either a license from the department of human services under Iowa Code section 237.3, subsection 2, paragraph *"a,"* subparagraph (3) or, for facilities which provide substance abuse treatment, a license from the department of public health under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

441—85.22(249A) Eligibility of persons under the age of 21.

85.22(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.22(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.22(3) *Certification for need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.22(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in rule 441—75.1(249A), except medically needy.

441—85.23(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.24(249A) Responsibilities of facilities.

85.24(1) *Medical record requirements.* The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.24(2) *Fiscal records.*

a. 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, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.24(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. Individual plan of care. An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care, or involved in consulting with or supervising those professionals involved in the direct provision of care.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.25(249A) Reimbursement to psychiatric medical institutions for children.

85.25(1) *Computation of inpatient rate.* Facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

a. Rates for new facilities are based on historical costs submitted on Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts, if the institution is established and has the historical data. If the institution is newly established, the rate shall be based on a proposed budget submitted on

Form 470-0664. A Form 470-0664 with actual cost data shall be submitted after at least six months of participation in the program for a new rate adjustment.

b. After the initial cost report period, the institution shall submit Form 470-0664 annually within three months of the close of the facility's fiscal year. Failure to submit the report 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.

c. For services rendered on or after August 1, 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1)*"a"* and *"b,"* subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

85.25(2) *Reserve bed payments.*

a. Reserve bed day payment for days a resident of a psychiatric medical institution for children is absent from the facility for hospitalization in an acute care general hospital is paid in accordance with the following policies:

(1) The intent of the department and the facility shall be for the resident to return to the facility after the hospitalization.

(2) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the hospitalization.

(3) Payment for reserve bed days shall be canceled and payment returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous hospital stay.

b. Reserve bed days for visitation shall be made for days a resident is absent from a psychiatric medical institution for children at the time of a nightly census for the purpose of visitation when the absence is in accordance with the following policies:

(1) The visits are consistent with the child's case permanency plan and the facility's individual case plan.

(2) The intent of the department and the facility shall be for the child to return to the facility after the visitation.

(3) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the visit.

(4) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment for reserve bed days shall be canceled effective the day after a decision not to return the child is made by the court or, in a voluntary placement, by the parent.

(6) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

c. Reserve bed payment shall be made for days a resident is absent from a psychiatric medical institution for children at the time of the nightly census for reasons such as detention, shelter care, or running away when the absence is in accordance with the following policies:

(1) The intent of the department and the psychiatric medical institution for children shall be for the child to return to the facility after the absence.

(2) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the

child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(3) Payment for reserve bed days shall be canceled effective the day after a decision is made not to return the child by the court or, in a voluntary placement, by the parent.

(4) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

(5) Reserve bed day payment is not available until the child has been physically admitted to the psychiatric medical institution.

(6) The psychiatric medical institution shall notify the department social worker within 24 hours after the child is out of the facility for running away or other unplanned reasons.

85.25(3) *Day treatment rates.* Outpatient day treatment services are paid on a fixed fee basis.

[**ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 0028C**, IAB 3/7/12, effective 4/11/12]

441—85.26(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections and appeals for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

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. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

441—85.27 to **85.40** Reserved.

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

441—85.41(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to department of inspections and appeals rules 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to department of inspections and appeals rule 481—51.33(135B). A distinct part of a general hospital may be considered a psychiatric institution. In addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall be 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).

441—85.42(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.

441—85.43(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A), except for medically needy.

441—85.44(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.45(249A) Responsibilities of nursing facility.

85.45(1) *Medical record requirements.* The facility shall obtain a PRO determination that the person requires psychiatric care when a person applying or eligible for Medicaid enters the facility, returns

from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.45(2) *Fiscal records.*

a. 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, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

441—85.46(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.

441—85.47(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness 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.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program and establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees. The purpose of this program is to provide transitional health and dental care coverage to children who are ineligible for Title XIX (Medicaid) assistance as set forth in this chapter. This chapter shall be construed to comply with all requirements for federal funding under Title XXI of the Social Security Act or under the terms of any applicable waiver of Title XXI requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XXI or the terms of any applicable waiver, the requirements of Title XXI or the terms of the waiver shall prevail.
[**ARC 0837C**, IAB 7/24/13, effective 10/1/13; **ARC 1287C**, IAB 1/8/14, effective 1/1/14]

441—86.1(514I) Definitions.

"Applicant" shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

"Benchmark benefit package for health care coverage" shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).
2. A health benefits coverage plan that is offered and generally available to state employees in this state.
3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

"Capitation rate" shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

"Contract" shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

"Cost sharing" shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

"Countable income" shall mean earned and unearned income of the family according to the modified adjusted gross income methodology.

"Covered services" shall mean all or a part of those medical and dental services set forth in rule 441—86.14(514I).

"Dentist" shall mean a person who is licensed to practice dentistry.

"Department" shall mean the Iowa department of human services.

"Director" shall mean the director of the Iowa department of human services.

"Eligible child" shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

"Emergency dental condition" shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

"Emergency medical condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

"Enrollee" shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

"Family" shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology.

"Federal poverty level" shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

"Good cause" shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee's control.
4. There was a failure to receive the third-party administrator's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

"HAWK-I board" or *"board"* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

"HAWK-I program" or *"program"* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

"Health insurance coverage" shall mean health insurance coverage as defined in 45 CFR Section 144.103, as amended to October 1, 2008.

"Health Insurance Marketplace" or *"Exchange"* shall mean the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) as amended to April 1, 2013, to evaluate and determine eligibility of applicants for Medicaid, the Children's Health Insurance Program (CHIP), and other health programs.

"Institution for mental diseases" shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, l994.

"Modified adjusted gross income" shall mean the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to April 1, 2013.

"Nonmedical public institution" shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, l994.

"Participating dental plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

"Participating health plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

"Physician" shall be defined as provided in Iowa Code subsection 135.1(4).

"Provider" shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

"Third-party administrator" shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09; **ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8580B**, IAB 3/10/10, effective 3/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility shall be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the HAWK-I program.

86.2(1) *Age.* The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child's nineteenth birthday.

86.2(2) *Income.*

a. *Countable income.* In determining initial and ongoing eligibility for the HAWK-I program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

b. *Verification of income.* Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers' statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

c. *Changes in income.* Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child's eligibility to participate in the HAWK-I program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) *Family size.* For purposes of establishing initial and ongoing eligibility under the HAWK-I program, the family size shall be determined according to the modified adjusted gross income methodology.

86.2(4) *Uninsured status.* The child must be uninsured.

a. A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. "Reasonable geographic access" means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider, or

(3) The child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology. If a child loses eligibility because of such loss of income disregards, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility regardless of the presence of other health insurance.

b. A child whose health insurance ends in the month of application shall be considered uninsured for purposes of HAWK-I eligibility. However, a one-month waiting period may be imposed pursuant to subrule 86.5(1) for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)*"c."*

c. American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

86.2(6) *Iowa residency.* Residency in Iowa is a condition of eligibility for the HAWK-I program. Residency shall be established in accordance with rule 441—75.10(249A).

86.2(7) *Citizenship and immigration status.* To be eligible for the HAWK-I program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the HAWK-I program.

a. The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for HAWK-I:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or immigration status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)*"f,"* applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)*"b"* shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)*"d," "e," "g," "h,"* and *"i."*

d. An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2)*"c."*

e. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the HAWK-I program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. "Nominal amount" shall mean $10 or less per month.

86.2(9) *Inmates of nonmedical public institutions.* The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, l994.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, l994.

86.2(11) *Furnishing a social security number.* As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under HAWK-I is being requested or received.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09; **ARC 7881B**, IAB 7/1/09, effective 7/1/09; **ARC 8109B**, IAB 9/9/09, effective 10/14/09; **ARC 8127B**, IAB 9/9/09, effective 9/1/09; **ARC 8280B**, IAB 11/18/09, effective 1/1/10; **ARC 8281B**, IAB 11/18/09, effective 12/23/09; **ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8838B**, IAB 6/16/10, effective 6/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13; **ARC 1287C**, IAB 1/8/14, effective 1/1/14]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for the HAWK-I program in accordance with rule 441—76.1(249A).

86.3(2) *Applications.* An application for the HAWK-I program shall be filed in accordance with rule 441—76.1(249A).

86.3(3) *Place of filing.* An application for the HAWK-I program may be filed with the third-party administrator responsible for making the eligibility determination through an Internet Web site, by telephone, through other electronic means, or in any local or area office of the department of human services, an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

86.3(4) *Date and method of filing.* The application is considered filed when received in accordance with rule 441—76.1(249A).

86.3(5) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application shall be documented, and the applicant shall be sent a notice of decision confirming the request.

86.3(6) *Application not required.*

a. An application shall not be required when a child becomes ineligible for Medicaid.

b. A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

c. A new application shall not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(7) *Information and verification procedure.* The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

a. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by e-mail, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization shall be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(8) *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the HAWK-I program shall be made within ten working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department or third-party administrator. Day one of the ten-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(9) *Applicant cooperation.* An applicant must cooperate with the third-party administrator in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(10) *Waiting lists.* When the department has established that all of the funds appropriated for this program are obligated, all subsequent applications for HAWK-I coverage shall be denied unless Medicaid eligibility exists.

a. The department or the third-party administrator shall mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

c. Applicants shall be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants shall be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties shall be determined by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, applicants shall be selected from the waiting list based on the order in which their names appear on the list and shall be notified of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the applicant's name shall be deleted from the waiting list and the next applicant on the waiting list shall be contacted.

[**ARC 8580B**, IAB 3/10/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0552C**, IAB 1/9/13, effective 4/1/13; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.4(514I) Coordination with Medicaid.

86.4(1) *HAWK-I applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the Medicaid program.

86.4(2) *HAWK-I enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in Medicaid effective the first day following the expiration of the 12-month HAWK-I enrollment period.

86.4(3) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the HAWK-I program if otherwise eligible.

[**ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)*"c"* when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

a. The child is moving from Medicaid to HAWK-I.

b. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

c. The cost of health insurance coverage for the child exceeds 5 percent of the family's gross income. The cost of health insurance for the child shall be the difference between the premium for coverage with and without the child.

d. The health insurance was provided through an individual plan.

e. The child's health insurance coverage was lost due to:

(1) Domestic violence.

(2) Divorce or death of a parent.

(3) An involuntary loss of employment that qualified the parent for dependent coverage, including but not limited to layoff, business closure, reduction in hours, or termination.

(4) A job change to a new employer that does not offer the parent dependent coverage or that requires a waiting period before children can be enrolled in dependent coverage.

(5) Utilization of the maximum lifetime coverage amount.

(6) Expiration of coverage under COBRA.

(7) Discontinuation of dependent coverage by the parent's employer.

(8) A reason beyond the control of the parent, such as a serious illness of the parent, fire, flood, or natural disaster.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the HAWK-I program due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

b. EXCEPTION: If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

86.5(3) *Annual renewals.* Coverage for children who are determined eligible for the HAWK-I program on the basis of an annual renewal shall be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) *Children added to an existing HAWK-I enrollment period.* Coverage for children who are determined eligible for the HAWK-I program on the basis of a request from the family to add the child to an existing enrollment period shall be effective the first day of the month following the month in which the request was made. However, if the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost unless the child is subject to a one-month waiting period in accordance with paragraph 86.2(4)*"b."*

[**ARC 8281B**, IAB 11/18/09, effective 12/23/09; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.6(514I) Selection of a plan. At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2)*"a"* apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

86.6(1) *Period of enrollment.* Once enrolled in a health or dental plan, the child shall remain enrolled in the selected health or dental plan for a period of 12 months.

a. *Exceptions.* A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraphs 86.6(2)*"b"* and *"c."*

b. *Request to change plan.* An enrollee may ask to change the health or dental plan:

(1) Within 90 days following the date the initial enrollment was sent to the health or dental plan regardless of the reason for the plan change or whether the original health or dental plan was selected by the applicant or was assigned in accordance with subrule 86.6(3).

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to May 13, 2010, includes, but is not limited to:

1. The enrollee moves out of the plan's service area.

2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.

3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

c. Response to request.

(1) If the enrollee has not requested to change health or dental plans within 90 days following the date the initial enrollment was sent to the health or dental plan and it is determined that cause does not exist, the request to change plans shall be denied.

(2) All approved changes shall be made prospectively and shall be effective on the first day of the month following the month in which the request was made.

86.6(2) *Failure to select a health or dental plan.* When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.

86.6(3) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.6(4) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the third-party administrator of a new health or dental plan choice by the end of the current 12-month enrollment period.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9084B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.7(514I) Cancellation. The child's eligibility for the HAWK-I program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Child moves from the service area.* Rescinded IAB 1/13/10, effective 3/1/10.

86.7(2) *Age.* The child shall be canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) *Nonpayment of premiums.* The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3), 86.8(4) and 86.8(5).

86.7(4) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

86.7(5) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the department or the third-party

administrator is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) *Admission to a nonmedical public institution.* The child shall be canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3)*"d"* apply.

86.7(8) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) *Employment with the state of Iowa.* The child shall be canceled from the HAWK-I program as of the first day of the month in which the child's parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The income considered in determining the premium amount shall be the family's countable income using the modified adjusted gross income methodology.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the HAWK-I program shall be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaskan Native; or

(2) The family's countable income is less than 181 percent of the federal poverty level for a family of the same size.

b. If the family's countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is $10 per child per month with a $20 monthly maximum per family.

c. If the family's countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is $20 per child per month with a $40 monthly maximum per family.

86.8(3) *Due date.*

a. *Payment upon initial application.* "Initial application" means the first program application or a subsequent application that is not a renewal. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. *Payment upon renewal.* "Renewal" means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the health and dental plans of the enrollment.

c. *Subsequent payments.* All subsequent premiums are due by the fifth day of each month for the next month's coverage and must be postmarked no later than the last day of the month before the month of coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. *Holiday or weekend.* When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) *Grace period.* A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)*"c."* The grace period shall be the coverage month for which the premium is due.

a. Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

b. If the premium is subsequently received, coverage will be reinstated if the premium was postmarked or otherwise paid:

(1) In the grace period, or

(2) In the 14 calendar days following the grace period.

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the third-party administrator.

86.8(6) *Failure to pay premium.* Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in cancellation from the program unless the grace period provisions of subrule 86.8(4) apply. Once a child is canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

86.8(7) *Copayment.* There shall be a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 150 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

86.8(8) *Program lock-out.* A child who has been disenrolled from the program due to nonpayment of premiums shall be locked out of the program until the arrearage is paid in full or for a period not to exceed 90 days, whichever occurs first.

a. Failure to pay the unpaid premiums shall result in denial of the application if less than 90 days has elapsed since the effective date of disenrollment. EXCEPTION: The unpaid premium obligation shall be reduced to zero if upon reapplication a premium would not be assessed because the household's income is less than 150 percent of the federal poverty level.

b. If the arrearage is not paid within 24 months of failing to pay a premium, the debt shall be expunged and shall no longer be owed.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09; **ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13; **ARC 1287C**, IAB 1/8/14, effective 1/1/14]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" shall be the first month in which coverage is provided.

86.9(1) *Review form.* A prepopulated review form on which the answers, except for income, have been completed based on the information on file shall be sent to the family. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

86.9(2) *Failure to provide information.* The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information shall be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

86.9(3) *Change in plan.* Rescinded IAB 1/13/10, effective 3/1/10.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8580B**, IAB 3/10/10, effective 3/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the department or the third-party administrator. "Timely" shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

86.10(1) *Entry to a nonmedical public institution.* The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

86.10(2) *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

86.10(3) *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

86.10(4) *Employment with the state of Iowa.* The employment of the child's parent with the state of Iowa shall be reported.

86.10(5) *Decrease in income.* If the family reports a decrease in income, the third-party administrator shall ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(6) *Information reported by a third party.* Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(7) *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(8) *Effective date of change in eligibility.*

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

[**ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.11(514I) Notice requirements. The applicant shall be provided an adequate written notice of the decision regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in 441—subrule 7.7(1).

[**ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

[**ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.13(514I) Third-party administrator. The third-party administrator shall have the following responsibilities:

86.13(1) *Determination of eligibility.* Eligibility for the HAWK-I program shall be determined utilizing the department's eligibility system and in accordance with the provisions of rule 441—86.2(514I).

86.13(2) *Dissemination of application forms and information.* The third-party administrator shall disseminate the following:

a. Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health and dental plan information.

d. Other materials as specified by the department.

86.13(3) *Toll-free dedicated customer services line.* The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

86.13(4) *HAWK-I program web site.* The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

86.13(5) *Application process.* Applications shall be processed in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

c. Applications shall be screened for completeness. Additional information or verification necessary to establish eligibility may be requested in writing. All information or verification of information attained shall be logged.

d. Health and dental plans shall be notified when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

86.13(6) *Effective date of coverage.* The effective date of coverage shall be established in accordance with the provisions of rule 441—86.5(514I).

86.13(7) *Selection of health or dental plan.* The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

86.13(8) *Enrollment.* The third-party administrator shall notify participating health and dental plans of enrollments.

86.13(9) *Disenrollments.* The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health and dental plans when an enrollee is disenrolled.

86.13(10) *Annual reviews of eligibility.* Eligibility shall be reviewed annually in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

86.13(11) *Acting on reported changes.* The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

86.13(12) *Premiums.* The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

86.13(13) *Notices to families.* Timely and adequate approval, denial, and cancellation notices that clearly explain the action being taken in regard to an application or an existing enrollment shall be issued

to the family. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

86.13(14) *Records.* The third-party administrator shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections and appeals.

b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.

c. Application, case and financial records.

d. All other records as required 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.

86.13(15) *Confidentiality.* The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

86.13(16) *Reports to the department.* The third-party administrator shall submit reports as required by the department.

86.13(17) *Systems.* The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff.
[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.14(514I) Covered services. The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

86.14(1) *Required medical services.* The participating health plan shall cover at a minimum the following medically necessary services:

a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).

b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).

c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).

d. Ambulance services.

e. Physical therapy.

f. Nursing care services (including skilled nursing facility services).

g. Speech therapy.

h. Durable medical equipment.

i. Home health care.

j. Hospice services.

k. Prescription drugs.

l. Rescinded IAB 1/13/10, effective 3/1/10.

m. Hearing services.

n. Vision services (including corrective lenses).

86.14(2) *Abortion.* Payment for abortion shall only be made under the following circumstances:

a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.

b. The pregnancy was the result of an act of rape or incest.

86.14(3) *Required dental services.* Participating dental plans shall cover at a minimum the following necessary dental services:

a. Diagnostic and preventive services.

b. Routine and restorative services.

c. Endodontic services.

d. Periodontal services.

e. Cast restorations.

f. Prosthetics.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10]

441—86.15(514I) Participating health and dental plans.

86.15(1) *Licensure.* The participating health or dental plan must:

a. Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or

b. Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

86.15(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.14(514I) to all children determined eligible.

a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.

b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

86.15(3) *Premium tax.* Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.15(7) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of the appeal to the enrollee.

c. Establishes time frames which ensure that appeals be resolved within 45 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

d. Ensures the participation of persons with authority to take corrective action.

e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.

f. Ensures the confidentiality of the enrollee.

g. Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.

h. Maintains a log of the appeals which is made available to the department at its request.

i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

(1) Identifies each medical or dental record by HAWK-I enrollee identification number.

(2) Maintains a complete medical or dental record for each enrollee.

(3) Provides a specific medical or dental record on demand.

(4) Meets state and federal reporting requirements applicable to the HAWK-I program.

(5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of services under the plan.

(2) Encounter data on a monthly basis as required by the department.

(3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

(1) Information regarding the plan's appeal process.

(2) A plan for a health improvement program.

(3) Periodic financial, utilization and statistical reports as required by the department.

(4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

86.15(10) *Systems.* The participating health or dental plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

86.15(11) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

86.15(12) *Quality assurance.* The health or dental plan shall have in effect an internal quality assurance system.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.16(514I) Clinical advisory committee. Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2)*"c"* shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

441—86.17(514I) Use of donations to the HAWK-I program. If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

86.17(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.17(2) If the donation is less than $5,000 and the donor does not specifically identify how it is to be used, the department shall use the moneys in the following order:

a. For the direct benefit of enrollees (e.g., premium payments).

b. For outreach activities.

c. For other purposes as determined by the HAWK-I board.

86.17(3) If the donation is more than $5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

441—86.18(505) Health insurance data match program. All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

441—86.19(514I) Recovery.

86.19(1) *Definitions.*

"Administrative error" means an action of the department or the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department or the HAWK-I third-party administrator.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

"Client error" means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

86.19(2) *Amount subject to recovery from the enrollee or representative.* The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.

b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) *Notification.* The enrollee shall be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

a. The name of the person for whom funds were incorrectly paid;

b. The period during which the funds were incorrectly paid;

c. The amount subject to recovery; and

d. The reason for the incorrect payment.

86.19(4) *Recovery.*

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.19(5) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8839B**, IAB 6/16/10, effective 8/1/10; **ARC 0552C**, IAB 1/9/13, effective 4/1/13; **ARC 0837C**, IAB 7/24/13, effective 10/1/13]

441—86.20(514I) Supplemental dental-only coverage.

86.20(1) *Definition.*

"Supplemental dental-only coverage" means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

86.20(2) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

86.20(3) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of subparagraph 86.8(2)*"a"*(1) or to families whose countable income is less than 152 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology.

b. If the family's countable income is equal to or exceeds 152 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.

c. If the family's countable income exceeds 203 percent of the federal poverty level but does not exceed 254 percent of the federal poverty level for a family of the same size, the premium is $10 per child per month with a $15 monthly maximum per family.

d. If the family's countable income exceeds 254 percent of the federal poverty level for a family of the same size, the premium is $15 per child per month with a $20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

f. The provisions of subrules 86.8(3) to 86.8(6) and 86.8(8) apply to premiums specified in this subrule.

86.20(4) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.
[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0837C**, IAB 7/24/13, effective 10/1/13; **ARC 1287C**, IAB 1/8/14, effective 1/1/14]

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CHAPTER 87
STATE-FUNDED FAMILY PLANNING PROGRAM

PREAMBLE

This chapter defines and structures the state-funded family planning program administered by the department pursuant to 2008 Iowa Acts, chapter 1187. The purpose of this program is to provide family-planning-related services to women who are ineligible for medical assistance under 441—subrule 75.1(41). The department is not receiving federal financial participation for state expenditures under the state-funded family planning program. Therefore, this chapter shall remain in effect only as long as state funding is available.

441—87.1(82GA,ch1187) Definitions.

"Applicant" means a person who applies for medical assistance under the state-funded family planning program described in this chapter.

"Department" means the Iowa department of human services.

"Family planning agency" means any Iowa Title X family planning agency or any family planning agency that was under contract with the department for the social services block grant family planning program as of July 1, 2004.

"Family planning services" means pregnancy prevention and related reproductive health services. These services shall not include abortion services.

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.2(82GA,ch1187) Eligibility. Eligibility for the state-funded family planning program shall be determined according to the provisions of this rule.

87.2(1) *Persons covered.* Subject to funding as described in subrule 87.2(3), medical assistance for family planning services shall be available to a woman who:

a. Is seeking pregnancy prevention services;

b. Is capable of bearing children but is not pregnant;

c. Is a resident of Iowa as defined in rule 441—75.10(249A);

d. Has income that does not exceed 200 percent of the federal poverty level as determined according to 441—paragraph 75.1(41)*"c"*;

e. Has been determined ineligible for medical assistance under 441—subrule 75.1(41) after having cooperated with the application process; and

f. Is eligible under 441—subrule 75.1(41) except for:

(1) Documentation of citizenship and identity pursuant to 441—paragraph 75.11(2)*"c," "d,"* or *"e"*;

(2) Enrollment in credible health insurance coverage; or

(3) Age.

87.2(2) *Citizenship.* To be eligible for state-funded family planning assistance, a woman must declare that she meets the requirements in 441—paragraph 75.11(2)*"a."* A woman who claims a qualified alien status shall provide documentation of this status.

87.2(3) *Funding contingency.* Initial and continuing eligibility for family planning services under this program is subject to the availability of funding appropriated for this purpose.

a. When appropriated funding is exhausted, ongoing eligibility shall be terminated and new applications shall be denied.

b. When appropriated funding becomes available, applications submitted thereafter will be considered on a first-come, first-served basis, based on the date of approval.

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.3(82GA,ch1187) Application. A woman who requests assistance for family planning services shall file an application for medical assistance as required in rule 441—76.1(249A). An application that is denied for medical assistance under 441—subrule 75.1(41) shall be considered an application for this coverage group.

87.3(1) *Place of filing.* An application may be filed at any family planning agency.

87.3(2) *Time limit for decision.* An application shall be investigated by the family planning agency with which the application was filed. A determination shall be made as defined in rule 441—76.3(249A).

87.3(3) *Notice of decision.* The applicant shall be notified in writing of the decision regarding the applicant's eligibility for the state-funded family planning program.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.4(82GA,ch1187) Effective date. Subject to the availability of funding appropriated for this purpose, assistance for family planning services under this program shall be effective on the first day of the month of application or the first day of the month in which all eligibility requirements are met, whichever is later. Assistance shall not be available under this program for any months preceding the month of application.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.5(82GA,ch1187) Period of eligibility and reapplication. Eligibility for family planning services under this program shall be limited to a period of 12 months from the effective date of eligibility, or the duration of appropriated funding, whichever is less. A new application shall be required for benefits to continue beyond this date.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.6(82GA,ch1187) Reporting changes.

87.6(1) *Required report.* A woman applying for or receiving family planning services under this program shall report to the family planning agency when she:

a. Has a change in health insurance coverage;

b. Is no longer a resident of Iowa;

c. Is no longer seeking services that prevent pregnancy; or

d. Is no longer capable of bearing children.

87.6(2) *Timeliness.* Reports shall be considered timely when received by the family planning agency within ten days from the date the change is known to the woman. When these changes are not timely reported, any program expenditures made in error shall be subject to recovery from the woman.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.7(82GA,ch1187) Allocation of funds.

87.7(1) Family planning agencies that wish to participate in this program shall send a letter of application to the department's bureau of health supports:

a. By January 15, 2009, for state fiscal year 2009; and

b. By June 1 of the preceding state fiscal year for subsequent fiscal years.

87.7(2) Family planning agencies participating in the state-funded family planning program shall receive no more than a proportionate share of the available funding during any state fiscal year, based on the number of applications filed at the agencies and approved pursuant to 441—subrule 75.1(41) during the preceding state fiscal year.

87.7(3) If a participating agency's allocation is not spent by June 1, the department shall reallocate unspent funds in proportion to the dollar amount of claims submitted under this program by that date in the state fiscal year.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.8(82GA,ch1187) Availability of services. Family planning services are payable for a woman enrolled in this program only when care is received at or authorized by a family planning agency.

87.8(1) Sterilization is a covered service subject to the limitations in 441—paragraphs 78.1(16)*"a"* through *"i."*

87.8(2) Covered services shall not include abortion services.
[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.9(82GA,ch1187) Payment of covered services. Payment for family planning services covered under this chapter, including services authorized but not provided by a participating family planning agency, shall be made only to participating family planning agencies on a fee schedule determined by the department.

87.9(1) *Fee schedule.* The fee schedule shall include the amount of payment for each service and any limits on the service (e.g., a routine Pap smear is payable once annually).

87.9(2) *Third-party payments.* This program is the payer of last resort for services covered in this chapter. Any third-party payment received by the family planning agency or other provider of services plus any payments under this program cannot exceed the fee schedule allowance.

87.9(3) *Supplementation.* Payment made under this program shall be considered payment in full.

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—87.10(82GA,ch1187) Submission of claims. Family planning agencies that participate in the program shall submit claims to the department for services rendered no later than 45 days from the last day of the month in which services were provided.

87.10(1) Claims shall be submitted to the department's bureau of health supports on Form 470-4675, State Family Planning Program Claim.

87.10(2) Following a successful review of the claim, the department shall make payments to the family planning agency subject to the availability of funding and the allocation of available funds under rule 441—87.7(82GA,ch1187).

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

These rules are intended to implement 2008 Iowa Acts, chapter 1187, section 29.

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CHAPTER 88
MANAGED HEALTH CARE PROVIDERS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Contract" shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

"Covered services" shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

"Department" shall mean the Iowa department of human services.

"Emergency care" shall mean those medical services rendered for an emergent medical condition or protection of the public health.

"Emergent medical condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

"Enrollment area" shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

"Extended-participation program" shall mean a mandatory six-month enrollment period with a managed care entity.

"Federally qualified HMO" shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

"Grievance" shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

"Health maintenance organization (HMO)" shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

"Managed health care review committee" shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

"Mandatory enrollment" shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Noncovered services" shall mean services covered under Medicaid which are not included in the HMO's contract with the department. Payment for these services will be made under regular Medicaid procedures.

"Participating providers" shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

"Recipient" shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

"Region" shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

"Routine care" shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

441—88.2(249A) Participation.

88.2(1) *Contracts with HMOs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules of the insurance division, 191—Chapter 40. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with HMOs.

a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) *Method of selection of HMO.* In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

b. *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) *Termination of contract.* The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—88.3(249A) Enrollment.

88.3(1) *Enrollment area.* Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) *Voluntary enrollment.* When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) *Mandatory enrollment.* Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4)*"b."* The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) *Identification card.* The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

(1) Attains initial eligibility for a covered category of service in a mandatory project county.

(2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.

(3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.

(4) Reattains eligibility.

(5) Has a new member of the household receiving a covered category of assistance.

c. Selection of a managed health care provider. A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

(1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3)*"a."*

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3)*"b."*

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

f. *Enrollment cycle.* Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) *Disenrollment request.* Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) *Disenrollment process.* The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. *Request for disenrollment by the recipient.* The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. *Request for disenrollment by the HMO.* With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or "drop-in" requests for service without making appointments.

88.4(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the HMO is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

c. The recipient permanently moves outside the HMO's enrollment area.

d. The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) *Amount, duration, and scope of services.* Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) *Required services.*

a. The HMO shall cover as a minimum the following services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Family planning services.

(5) Home health agency services.

(6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.

(7) Laboratory and X-ray services.

(8) Rural health clinic services (where available).

(9) Advanced registered nurse practitioners.

(10) Optometric and ophthalmology services.

(11) Clinic services.

(12) Ambulance services.

(13) Rescinded IAB 11/5/97, effective 1/1/98.

(14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).

(15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

a. Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).

b. Inpatient psychiatric care provided at state-administered mental health institutes.

c. Services provided by the area education agencies.

d. Services provided at psychiatric medical institutions for children.

e. Dental services.

f. Hospice services.

g. Mental health services as defined in rule 441—88.65(249A).

h. Rescinded IAB 8/1/07, effective 9/5/07.

i. Psychiatric services.

j. Infant and toddler program services.

k. Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) *Restrictions and limitations.* If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) *Recipient use of HMO services.* A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) *Availability of services.* The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) *HMO payment liability.* HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) *Notification and claim filing time spans.* The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) *Provision of urgent care.* If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) *Medical service delivery sites.* Medical service delivery sites must have the following specific characteristics:

a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) *Adequate appointment system.* The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) *Adequate after hours call-in coverage.* The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

a. Twenty-four-hour-a-day phone coverage shall exist.

b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) *Adequate referral system.* The HMO must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) *Written procedure.* The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) *Written record.* All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) *Information concerning grievance procedures.* The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) *Appeals to the department.* A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) *Periodic report to the department.* The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

88.8(6) *Consent for state fair hearing.* Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[**ARC 0583C**, IAB 2/6/13, effective 4/1/13]

441—88.9(249A) Records and reports.

88.9(1) *Medical records system.* The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

a. Identifies each medical record by state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) *Content of individual medical record.* The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) *Confidentiality of records.* HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide

services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph *"e"* of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) *Reports to the department.* Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO's fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department's discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) *General requirements.* An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual's enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of "cold-call" marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

88.10(2) *Marketing representatives.* Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO's marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) *Marketing presentations.* The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) *Health education procedures.* The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) *Use of services.* The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) *Patient rights and responsibilities.* The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) *Capitation rate.* In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) *Determination of rate.* The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) *Third-party liability.* If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other

than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to **88.20** Reserved.

DIVISION II
PREPAID HEALTH PLANS

441—88.21(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Contract" shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

"Department" shall mean the Iowa department of human services.

"Emergency service" shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient's health.

"Enrollment area" shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

"Grievance" shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

"Managed health care" shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

"Managed health care review committee" shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

"Managed services" shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

"Nonmanaged services" shall mean medical services covered under regular Medicaid, but which are not covered in the PHP's contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

"Participating providers" shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

"Prepaid health plan (PHP)" shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

"Recipient" shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

"Routine care" shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or

health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

"Urgent, nonemergency need" shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

441—88.22(249A) Participation.

88.22(1) *Contracts with PHPs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.22(2) *Method of selection of PHP.* In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

88.22(3) *Termination of contract.* Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

a. The PHP's delivery system does not ensure enrolled recipients adequate access to medical services.

b. The PHP's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of solvency on the part of the PHP.

d. There is not substantial compliance with all provisions of the contract.

e. The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.22(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—88.23(249A) Enrollment.

88.23(1) *Enrollment area.* Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(2) *Voluntary enrollment.* When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

88.23(3) *Mandatory enrollment.* In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

88.23(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

88.23(5) *Identification card.* The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

88.23(6) *Assignment methodology.* When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

a. Notification. Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

b. Limitations. Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

c. Household member enrollment. Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

d. Assigned recipients who desire another choice. Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(1) *Disenrollment request.* An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.24(3) *Disenrollment process.* If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

a. Request for disenrollment by the recipient. In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care

programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

b. *Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

(1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.

(2) There is evidence of unauthorized use of the PHP identification card.

(3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

88.24(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the PHP is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.

c. The recipient permanently moves outside the PHP's enrollment area.

d. The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

88.24(5) *No disenrollment for health reasons.* No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(1) *Amount, duration, and scope of services.* Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

88.25(2) *Mandatory services.*

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Family planning services.

(5) Home health agency services.

(6) Laboratory and X-ray services.

(7) Early periodic screening, diagnosis and treatment for persons under age 21.

(8) Rural health clinic services (where available).

(9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

88.25(3) *Excluded services.* Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

88.25(4) *Restrictions and limitations.* If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

88.25(5) *Recipient use of PHP services.* An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2)*"c,"* and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(1) *Availability of services.* The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP's own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

88.26(2) *PHP payment liability.* PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP's enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP's enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.26(3) *Notification and claim filing time span.* The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

441—88.27(249A) Access to service.

88.27(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

88.27(2) *Medical service delivery sites.* Medical service delivery sites shall have the following specific characteristics:

a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.27(3) *Adequate appointment system.* The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.27(4) *Adequate after hours call-in coverage.* The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.27(5) *Adequate referral system.* The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.28(249A) Grievance procedures.

88.28(1) *Written procedure.* The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

88.28(2) *Written record.* All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

88.28(3) *Information concerning grievance procedures.* The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

88.28(4) *Appeals to the department.* A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

88.28(5) *Periodic report to the department.* The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(1) *Medical records system.* The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

a. Identifies each medical record by the departmentally assigned state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

i. Meets state and federal reporting requirements applicable to PHPs.

88.29(2) *Content of individual medical record.* The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.29(3) *Confidentiality of records.* PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).

d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information.

f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

88.29(4) *Reports to the department.* Each PHP shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the PHP's fiscal year.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

88.29(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.30(249A) Marketing.

88.30(1) *Marketing procedures.* All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

88.30(2) *Marketing representatives.* Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP's marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which

ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

88.30(3) *Marketing presentations.* The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

88.30(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

441—88.31(249A) Patient education.

88.31(1) *Use of services.* The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

88.31(2) *Patient rights and responsibilities.* The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

441—88.32(249A) Payment to the PHP.

88.32(1) *Capitation rate.* In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

88.32(2) *Determination of rate.* The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.32(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

88.32(4) *Third-party liability.* If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

441—88.33(249A) Quality assurance. The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.34 to **88.40** Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT

441—88.41(249A) Definitions.

"Contract" shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

"Covered eligibles" shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

"Department" shall mean the Iowa department of human services.

"Designee" shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

"Eligible providers" shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

"Emergency care" shall mean those medical services rendered for an emergent medical condition or protection of the public health.

"Emergent medical condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

"Extended-participation program" shall mean mandatory six-month enrollment period with a managed care entity.

"Grievance" shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

"Managed health care review committee" shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

"Mandatory enrollment" shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the

needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Managed services" shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

"Medical service area" means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

"MediPASS" shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

"Nonmanaged services" shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

"Patient management" shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

"Patient manager" shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) *Included categories of assistance.* All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient's county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) *Excluded categories of assistance.* The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

a. Medically needy recipients as defined in 441—subrule 75.1(35).

b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Automatic redetermination recipients as defined in rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

441—88.43(249A) Project area.

88.43(1) *Designation as a mandatory project county.* The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) *Voluntary project counties.* The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) *Expansion to other counties.* Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) *Specialties allowed.* Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)*"d."*

b. Is otherwise eligible to enroll as an Iowa Medicaid provider.

c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

d. Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

88.44(2) *Clinic or group practice participation.* A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) *Exceptions.* Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2)*"c,"* the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

(1) Mutual agreement between physician and patient regarding the arrangement.
(2) Existence of an already established physician-patient relationship.
(3) Transportation barriers, if requesting a patient manager outside the medical service area.
(4) Customary practice by the specialist to provide primary care.
(5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) *Eligibility to contract.* Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) *Contract provisions.* The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

c. The patient manager shall maintain records that at a minimum:

(1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

e. The department shall specify the fees and method of payment to patient managers.

f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) *Contract compliance.* The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) *Corrective action and sanctions.* The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) *Termination of contract.* The contract may be terminated in any of the following ways:

a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

(1) The department has imposed any sanction described at 441—subrule 79.2(3).

(2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) *Mandatory enrollment.* Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. *Timely notice.* Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. *Enrollment.* Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

(1) Attains initial eligibility for a covered category of service in a mandatory project county.

(2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.

(3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.

(4) Reattains eligibility.

(5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. Selection of a managed health care provider. A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

f. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

(1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3)*"a."*

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3)*"b."*

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

g. Enrollment cycle. Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) *Voluntary enrollment procedures.* Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

a. Recipients shall not be informed at the face-to-face interview that enrollment is required.

b. Notice to recipient shall not include assignment language.

c. Recipients shall not be assigned if no selection is made voluntarily.

d. A managed health care provider must be available for enrollment.

88.46(4) *Effective date.* Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) *Identification card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) *Enrollment limits.*

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

(1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.

(2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

(3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) *Reinstatement of patient management status.* When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) *Disenrollment request.* An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1)*"c"* (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) *Effective date.* Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) *Managed services.* Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

a. Inpatient hospital.

b. Outpatient hospital.

c. Home health.

d. Physician (except services provided by an ophthalmologist).

e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).

f. Laboratory, X-ray.

g. Medical supplies.

h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.

i. Rescinded IAB 11/5/97, effective 1/1/98.

j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

Services or parts thereof described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, require authorization by the patient manager as otherwise required by this division.

88.48(2) *Nonmanaged services.* Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) *Authorizing managed services.* The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient

manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) *Special authorizations.* Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph *"b."*

[**ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—88.49(249A) Grievance procedure. The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) *Written record.* The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) *Formal grievance resolution and response.* The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) *Repeated grievances.* Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) *Quality of care grievances.* In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) *Information concerning grievance procedures.* The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) *Appeals to the department.* A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) *Fee.* Patient managers shall be paid a monthly fee of $2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) *Basis for payment.* Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) *Mode of payment.* The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) *Payment limit.* Payment shall be limited to $3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) *Measured services.* Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) *Reports to patient managers.* Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) *Managed health care advisory committee.* Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

b. Assist the department in establishing options for managed health care quality assessment.

c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).

d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.

e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.

f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) *Service market.* A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) *Prohibition of "cold-call" marketing.* MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

441—88.53 to **88.60** Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

"Accredited" shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

"Appeal" shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member's designee, may request review of a certain decision made by the department or the contractor.

"ASAM-PPC-2R" shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

"Assertive community treatment (ACT) program" shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

"Capitation rate" shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

"Certification" shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

"Clinical decision review" shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

"Contract" shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

"Contractor" shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

"Coverage group" shall mean a category of members who meet certain common eligibility requirements.

"Covered services" shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

"Department" shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

"Designee" shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

"Director" shall mean the director of the Iowa department of human services.

"Disenrollment" shall mean the removal of an enrollee from the contractor's enrollment list either through loss of eligibility or some other cause.

"Emergency services" shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

"Encounter data" shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

"Enrollee" shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

"Enrollment" shall mean the inclusion of a Medicaid member on a contractor's Medicaid enrollment file.

"Enrollment area" shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

"Fee-for-service" shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined

services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

"Grievance" shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor's staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

"Insolvency" shall mean a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

"Integrated mental health services and supports" shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

"Iowa Plan" shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

"Licensed" shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

"Member" shall mean a person determined eligible for Medicaid.

"Mental health services" shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

"MHI" shall mean a state mental health institute operated by the department.

"Open panel" shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

"Participating providers" shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

"Prepaid health plan (PHP)" shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

"Prior authorization" shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

"Psychosocial necessity" shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee's clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g.,

availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.

"Required services" shall mean mental health and substance abuse treatment services and supports which are not reimbursable though the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

"Retroactive eligibility" shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

"Routine care" shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider. Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"Service necessity" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"Substance abuse licensed PMIC" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"Substance abuse services" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"Targeted case management services" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"Third party" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

"Urgent, nonemergency care" shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient's life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

441—88.62(249A) Participation.

88.62(1) *Contract.* The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

(1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) *Assessment of penalties.* Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

441—88.63(249A) Enrollment.

88.63(1) *Enrollment area.* The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) *Members subject to enrollment.* All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) *Others to be served.* The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) *Voluntary enrollment.* There will be no voluntary enrollment in the Iowa Plan.

88.63(5) *Effective date.* For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) *Medical card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) *Disenrollments by the department.* Disenrollments shall occur when:

a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.

b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.

c. The enrollee dies.

88.64(2) *Effective date.* Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) *No disenrollment for health reasons.* No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) *Amount, duration, and scope of services.* The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) *Enrollee use of Iowa Plan services.* Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) *Covered, required and optional mental health services.*

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

(1) Ambulance services for psychiatric conditions.

(2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.

(3) Inpatient hospital care for psychiatric conditions.

(4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.

(5) Partial hospitalization.

(6) Day treatment.

(7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.

(8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.

(9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.

(10) Services provided through a community mental health center.

(11) Targeted case management services to persons with chronic mental illness.

(12) Medication management.

(13) Psychiatric nursing services by a home health agency.

(14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.

(15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

(16) Behavioral health intervention as set forth in rule 441—78.12(249A).

(17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.

(18) Home- and community-based habilitation services as described at rule 441—78.27(249A).

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

(1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.

(2) Services of a licensed social worker for treatment of mental illness.

(3) Mobile crisis services.

(4) Mobile counseling services.

(5) Integrated mental health services and supports.

(6) Psychiatric rehabilitation services.

(7) Peer support services for persons with chronic mental illness.

(8) Community support services.

(9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.

(10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) *Covered and required substance abuse services.* The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

a. Outpatient services (all Level I services according to the ASAM-PPC-2R).

b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).

c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).

d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).

e. Detoxification.

f. PMIC substance abuse treatment services.

g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.

h. Ambulance services for substance abuse conditions.

i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) *Covered diagnoses.* Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.

2. Substance abuse: 303-305.9.

88.65(6) *Excluded services.* Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

88.65(7) *Iowa wellness plan service benefits.* Services described in 441—Chapter 74 that otherwise constitute covered services pursuant to this rule shall be included in Iowa Plan services for members enrolled in the Iowa Plan who are also Iowa wellness plan members.

[**ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1135C**, IAB 10/30/13, effective 10/2/13]

441—88.66(249A) Emergency services.

88.66(1) *Availability of services.* The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) *Payment for emergency room services.* Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) *Contractor payment liability.* The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) *Notification and claim filing time spans.* The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) *Choice of provider.* Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) *Open panel requirement.* The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) *Requirements for participating provider panel.* The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where

capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) *Adequate appointment system.* The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) *Adequate after-hours call-in coverage.* The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) *Adequate referral system.* The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) *Discharge planning.* The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) *Lack of discharge plan.* When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8)*"a."*

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) *Clinical decision review.* The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.

b. Allow for participation by the enrollee and the provider.

c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.

d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.

e. Ensure the participation of contractor staff with authority to require corrective action.

f. Include at least one level of internal review.

g. Ensure the confidentiality of the enrollee.

88.68(2) *Appeal to department.* Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) *Review of nonclinical decisions.* The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

a. Allow initiation both verbally and in writing.

b. Require a review conducted by someone other than the person who made the original decision.

c. Require written notice acknowledging the receipt of a complaint or grievance.

d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) *Written record.* All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.* The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) *Periodic reports to the department.* The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

88.68(7) *Consent for state fair hearing.* Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[**ARC 0583C**, IAB 2/6/13, effective 4/1/13]

441—88.69(249A) Records and reports.

88.69(1) *Records system.* The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.

c. Permit effective professional review for medical audit processes.

d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.

e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) *Content of individual treatment record.* The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) *Confidentiality of mental health information.* The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) *Confidentiality of substance abuse information.* The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) *Reports to the department.* The contractor shall submit reports to the department as follows:

a. Encounter data on a monthly basis.

b. Annual audited financial statements no later than 180 days after the close of each contract year.

c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

d. Other reporting requirements as specified in the contract.

88.69(6) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) *Use of services.* The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) *Outreach to members with special needs.* The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) *Patient rights and responsibilities.* The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) *Capitation rate.* In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) *Determination of rate.* The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) *Payment for services to other recipients.* When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) *Third-party liability.* If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) *Claims payment by contractor.* The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) *Limits on payment responsibility for services.*

a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

f. Payment responsibility for services provided under the "keep kids safe" policy is set forth at subrule 88.67(8).

88.73(3) *Payment to nonparticipating providers.* In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) *Payment of crossover and copayments.* Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) Quality assurance. The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) Iowa Plan advisory committee. The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to **88.80** Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) Scope and definitions.

88.81(1) *Purpose.* A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

a. Enhance the quality of life and autonomy of frail older adults.

b. Maximize the dignity of and respect for frail older adults.

c. Enable frail older adults to live in the community as long as medically and socially feasible.

d. Preserve and support frail older adults' family units.

88.81(2) *Scope.* PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

88.81(3) *Authorization.* A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

88.81(4) *Definitions.* For purposes of this division:

"Alternate PACE service site" means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

"Capitation rate" means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

"Contract year" means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

"Department" means the Iowa department of human services.

"Enrollee" means a person who is enrolled in a PACE program.

"Federal PACE regulations" means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

"Interdisciplinary team" means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

"Medicaid enrollee" means a Medicaid member who is enrolled in a PACE program.

"Medicare beneficiary" means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

"Medicare enrollee" means a Medicare beneficiary who is enrolled in a PACE program.

"PACE" means programs of all-inclusive care for the elderly.

"PACE center" means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. "Primary care" shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

"PACE enrollment agreement" means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

"PACE organization" means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

"PACE program" means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

"PACE program agreement" means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

"Service area" means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

"Services" means both items and services provided to an enrollee by the PACE organization.

"Trial period" means the first three contract years in which a PACE organization operates under a PACE program agreement.

441—88.82(249A) PACE organization application and waiver process. This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

88.82(1) *Application requirements.* A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp.

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(2) *Waiver of federal requirements.* A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(3) *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

88.82(4) *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

441—88.83(249A) PACE program agreement. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

88.83(1) *Content and terms of agreement.*

a. *Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

b. *Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)*"a"*(5).

(2) Contain any additional terms and conditions agreed to by the parties.

88.83(2) *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

88.83(3) *Enforcement of agreement.* If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.

c. Terminate the PACE program agreement.

88.83(4) *Termination of agreement by the department.*

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph *"c"* of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department's determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph *"b"* of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

88.83(5) *Termination of agreement by PACE organization.* A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

88.83(6) *Transitional care during termination.* A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee's medical records available to new providers.

441—88.84(249A) Enrollment and disenrollment. A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

88.84(1) *Eligibility for Medicaid enrollees.* To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.

(4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(5) The department must determine that the person needs the nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. Other eligibility requirements.

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

88.84(2) *Effective date of enrollment.* A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

88.84(3) *Duration of enrollment.* Enrollment continues until the enrollee's death unless either of the following actions occurs:

a. The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

b. The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

88.84(4) *Annual recertification.*

a. At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

b. Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

88.84(5) *Involuntary disenrollment.* An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

a. Reasons for involuntary disenrollment. An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5)*"b."*

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4)*"b."*

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

b. Disruptive or threatening behavior. "Disruptive or threatening behavior" refers to either of the following:

(1) Behavior that jeopardizes the enrollee's health or safety or the safety of others; or

(2) Consistent refusal by the enrollee to comply with the enrollee's individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

c. *Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee's medical record:

(1) The reasons for proposing to disenroll the enrollee.

(2) All efforts to remedy the situation.

d. *Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee's behavior jeopardizes the enrollee's health or safety or the safety of others. "Noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to keep appointments.

88.84(6) *Effective date of disenrollment.*

a. In disenrolling a Medicaid enrollee, the PACE organization must:

(1) Use the most expedient process allowed under the PACE program agreement;

(2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and

(3) Give reasonable advance notice to the enrollee.

b. Until the date when enrollment is terminated, the following requirements must be met:

(1) The PACE organization must continue to furnish all needed services.

(2) The enrollee must continue to use PACE organization services.

88.84(7) *Documentation of disenrollment.* A PACE organization must meet the following requirements:

a. Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

b. Make documentation available for review by CMS and the department.

c. Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

88.84(8) *Reinstatement in other Medicare and medicaid programs.* After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee's reinstatement in other Medicare and Medicaid programs by:

a. Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and

b. Ensuring that medical records are made available to new providers in a timely manner.

88.84(9) *Reinstatement in PACE.* A previously disenrolled enrollee may be reinstated in a PACE program.

[**ARC 0758C**, IAB 5/29/13, effective 8/1/13]

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(1) *Required services.* The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

a. All Medicare-covered items and services.

b. All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

c. Other services determined necessary by the enrollee's interdisciplinary team to improve or maintain the enrollee's overall health status.

88.85(2) *Excluded services.* The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

88.85(3) *Service delivery.* The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

(1) The PACE center,

(2) The enrollee's home, and

(3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

88.85(4) *Minimum services furnished at a PACE center.* At a minimum, the following services must be furnished at each primary or alternate PACE center:

a. Primary care, including physician and nursing services.

b. Social services.

c. Restorative therapies, including physical therapy and occupational therapy.

d. Personal care and supportive services.

e. Nutritional counseling.

f. Recreational therapy.

g. Meals.

88.85(5) *Primary care.* Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

a. Managing an enrollee's medical situations; and

b. Overseeing an enrollee's use of medical specialists and inpatient care.

88.85(6) *Out-of-network emergency care.* A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"Emergency medical condition" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

"Emergency services" means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization's service area.

"Poststabilization care" means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

"Urgent care" means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee's life or functioning is not in severe jeopardy.

b. Plan. A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.

2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

c. Explanation to enrollee. The organization must ensure that the enrollee or caregiver, or both, understand:

(1) When and how to access out-of-network emergency services, and

(2) That no prior authorization is needed.

441—88.86(249A) Access to PACE services. An enrollee's access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee's health and social status.

88.86(1) *Interdisciplinary team.* A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. Team composition. The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) PACE center manager.

(9) Home care coordinator.

(10) Personal care attendant or attendant's representative.

(11) Driver or driver's representative.

b. Team responsibilities. Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. *Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) *Initial assessment.* The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

c. The assessment of each enrollee must include, but not be limited to, assessment of the following:

(1) Physical and cognitive function and ability.

(2) Medication use.

(3) Enrollee and caregiver preferences for care.

(4) Socialization and availability of family support.

(5) Current health status and treatment needs.

(6) Nutritional status.

(7) Home environment, including home access and egress.

(8) Enrollee behavior.

(9) Psychosocial status.

(10) Medical and dental status.

(11) Enrollee language.

88.86(3) *Plan of care.* The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. *Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. *Content.* The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

c. *Documentation.* The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. *Implementation.* The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. Evaluation. On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) *Reassessment.*

a. Semiannual reassessment. On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Recreational therapist or activity coordinator.

(5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. Annual reassessment. On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Physical therapist.

(2) Occupational therapist.

(3) Dietitian.

(4) Home care coordinator.

c. Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2)*"a"* must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. Changes to plan of care. Interdisciplinary team members who conduct a reassessment must:

(1) Reevaluate the enrollee's plan of care.

(2) Discuss any changes in the plan of care with the interdisciplinary team.

(3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.

(4) Document all assessment and reassessment information in the enrollee's medical record.

(5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) *Procedures for resolving enrollee request to change the plan of care.* The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph *"b"* of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

(1) The enrollee or designated representative requests the extension; or

(2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and

(2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

441—88.87(249A) Program administrative requirements. A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

88.87(1) *Enrollee rights.* A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

88.87(2) *Data collection, record maintenance, and reporting.* A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

88.87(3) *Quality assessment and performance improvement.* A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

88.87(4) *Federal and state monitoring.*

a. The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

(1) Corrective action required pursuant to 42 CFR Section 460.194; and

(2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

b. The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.

441—88.88(249A) Payment.

88.88(1) *Medicaid payment to PACE organization.* Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

88.88(2) *Liability of Medicaid enrollee.* A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

PREAMBLE

This chapter provides for the establishment of a debt for medical assistance due to a transfer of assets for less than fair market value. These rules allow the department to establish a debt against a person who receives the transferred assets from a Medicaid applicant or recipient within five years prior to an application for medical assistance if the applicant is approved for Medicaid. The debt is established against the transferee in an amount equal to the medical assistance provided, but not in excess of the fair market value of the assets transferred.

441—89.1(249F) Definitions.

"Department" shall mean the department of human services.

"Dwelling" shall mean real property in which a person has an ownership interest and which serves as the person's principal place of residence. Real property shall include the shelter in which the person lives, the land on which the shelter is located and related buildings on the land.

"Fair market value" shall mean the price for which property or an item could have been sold on the open market at the time of transfer.

"Medical assistance" shall mean "medical assistance," "additional medical assistance," "discretionary medical assistance" or "Medicare cost sharing" as each is defined in Iowa Code section 249A.2 which is provided to a person pursuant to Iowa Code chapter 249A and Title XIX of the federal Social Security Act.

"Property" shall mean anything of value, including both tangible and intangible property, real property and personal property.

"Transfer" shall mean the disposal of property for less than fair market value through gifting, sale or any transfer or assignment of a legal or equitable interest in property.

"Transferee" shall mean the person who receives a transfer or assignment of a legal or equitable interest in property for less than fair market value.

"Transferor" shall mean the person who makes a transfer of a legal or equitable interest in property for less than fair market value.

441—89.2(249F) Creation of debt.

89.2(1) *Transfer of property.* Except as provided in rule 441—89.3(249F), any transfer of property for less than fair market value creates a debt due and owing to the department from the transferee if:

a. The transfer is made while the transferor is receiving medical assistance or within five years prior to application for medical assistance and on or after July 1, 1993.

b. The transfer is made with the intent on the part of the transferee of enabling the transferor to obtain or maintain eligibility for medical assistance.

89.2(2) *Amount of debt.* The amount of the debt is the lesser of:

a. An amount equal to the medical assistance provided to or on behalf of the transferor on or after the date of the transfer.

b. The difference between the fair market value of the property at the time of transfer and the value of any consideration received.

441—89.3(249F) Exceptions. Notwithstanding rule 441—89.2(249F), exceptions for transfers that occur between July 1, 1993, and June 30, 1996, are in accordance with the rules during that time period. Notwithstanding rule 441—89.2(249F), the following exceptions apply to transfers that occur on or after July 1, 1996. The following transfers do not create a debt to the department:

1. Transfers to or for the sole benefit of the transferor's spouse, including a transfer to a spouse by an institutionalized spouse pursuant to Section 1924(f)(1) of the federal Social Security Act.

2. Transfers to or for the sole benefit of the transferor's child who is blind or disabled, as defined in Section 1614 of the federal Social Security Act.

3. Transfer of a dwelling, which serves as the transferor's home as defined in 20 CFR Section 416.1212, as amended to August 23, 1994, to a child of the transferor under 21 years of age.

4. Transfer of a dwelling, which serves as the transferor's home as defined in 20 CFR Section 416.1212, as amended to August 23, 1994, after the transferor is institutionalized, to either of the following:

- A sibling of the transferor who has an equity interest in the dwelling and who was residing in the dwelling for a period of at least one year immediately prior to the date the transferor became institutionalized.
- A child of the transferor who was residing in the dwelling for a period of at least two years immediately prior to the date the transferor became institutionalized and who provided care to the transferor which permitted the transferor to reside at the dwelling rather than in an institution or facility.

5. Transfers of less than $2,000. All transfers by the same transferor during the five-year period prior to the application for medical assistance by the transferor shall be aggregated. If a transferor transfers property to more than one transferee during the five-year period prior to application for medical assistance by the transferor, the $2,000 exemption shall be divided equally between the transferees for the five-year period prior to application for medical assistance.

6. Transfers that would, at the time of the transferor's application for medical assistance, have been exempt from consideration as a resource if they had been retained by the transferor, pursuant to 42 U.S.C. Section 1382(b)(a).

7. Transfers to a trust established solely for the benefit of the transferor's child who is blind or permanently and totally disabled as defined in Section 1614 of the federal Social Security Act.

8. Transfers to a trust established solely for the benefit of a person under 65 years of age who is disabled, as defined in Section 1614 of the federal Social Security Act.

9. Rescinded IAB 11/29/00, effective 1/3/01.

441—89.4(249F) Presumption of intent. Any transfer of property for less than fair market consideration made while the transferor is receiving medical assistance or within five years prior to an application for medical assistance is presumed to be made with the intent, on the part of the transferee, of enabling the transferor to obtain or maintain eligibility for medical assistance. This presumption can be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was no part of the transferee's reason for accepting the transfer of property.

441—89.5(249F) Notice of debt. The department may issue a notice establishing and demanding payment of an accrued or accruing debt due and owing to the department as provided in rule 441—89.2(249F). The notice shall be sent by restricted certified mail, as defined in Iowa Code section 618.15, to the transferee at the transferee's last-known address. If service of the notice is unable to be completed by restricted certified mail, the notice shall be served upon the transferee in accordance with the Iowa Rules of Civil Procedure. The notice shall include all of the following:

89.5(1) *Amount of debt.* The amount of medical assistance provided to the transferor to date which creates the debt.

89.5(2) *Computation of debt.* A computation of the debt due and owing.

89.5(3) *Demand for payment.* A demand for immediate payment of the debt.

89.5(4) *Request for conference.*

a. A statement that if the transferee desires to discuss the notice, the transferee may contact the department and request an informal conference.

b. A statement that, if a conference is requested, the transferee has until 10 days after the date set for the conference or until 20 days after the date of service of the original notice, whichever is later, to send a written request for a hearing to the department.

c. A statement that after the conference, the department may issue a new notice to be sent to the transferee or the transferee's attorney.

d. A statement that if the department issues a new notice the transferee has until 10 days after the date of mailing of the new notice or until 20 days after the date of service of the original notice to send a written request for a hearing to the department.

89.5(5) *Request for hearing without conference.* A statement that the transferee has until 20 days after the date of service of the original notice to send a written response setting forth any objections and requesting a hearing to the department.

89.5(6) *Hearing in district court.* A statement that if a timely written request for a hearing is received by the department, the transferee has the right to a hearing to be held in district court; and if no timely written request for hearing is received, the department shall enter an order in accordance with the latest notice.

89.5(7) *Collection action.* A statement that as soon as the order is entered the property of the transferee is subject to collection action including, but not limited to, wage withholding, garnishment, attachment of a lien, issuance of a distress warrant, or execution.

89.5(8) *Responsibilities of transferee.* A statement that the transferee must give the department written notice of any change of address or employment.

89.5(9) *Questions.* A statement that if the transferee has any questions regarding the transfer of assets, the transferee should contact the department or consult an attorney.

89.5(10) *Other information.* Other information as the department finds appropriate.

441—89.6(249F) No timely request of a hearing.

89.6(1) *Entering of order.* If a timely written request for hearing is not received by the department, the department may enter an order in accordance with the latest notice. The order is final, and action by the department to enforce and collect upon the order may be taken from the date of the issuance of the order.

89.6(2) *Order.* The transferee shall be sent a copy of the order by first-class mail addressed to the transferee at the transferee's last known address or, if applicable, to the transferee's attorney at the last known address of the transferee's attorney. The order shall specify:

a. The amount to be paid with directions as to the manner of payment.

b. The amount of the debt accrued and accruing in favor of the department.

c. Notice that the property of the transferee is subject to collection action including, but not limited to, wage withholding, garnishment, attachment of a lien, issuance of a distress warrant, and execution.

441—89.7(249F) Timely request for a hearing. If a timely written request for a hearing is received by the department, the department shall certify the matter for hearing to the district court where the transferee resides or to the district court where the transferor resides if the transferee is not an Iowa resident. If neither the transferor nor the transferee resides in Iowa, the order may be filed in any county in which the transferor formerly resided.

The certification shall include true copies of the original notice, the return of service, any request for an informal conference, if applicable, any subsequent notices, the written request for hearing, and true copies of any administrative orders previously entered.

441—89.8(249F) Department-requested hearing. The department may also request a hearing on its own motion regarding the determination of a debt at any time prior to entry of an administrative order.

441—89.9(249F) Filing and docketing of the order. A true copy of an order entered by the department, pursuant to this chapter, along with a true copy of the return of service, if applicable, may be filed in the office of the clerk of the district court in the county in which the transferee resides or, if the transferee resides in another state, in the office of the district court in the county in which the transferor resides. The department's order shall be presented, ex parte, to the district court for review and approval.

441—89.10(249F) Exemption from Iowa Code chapter 17A. Actions initiated under Iowa Code chapter 249F are not subject to Iowa Code chapter 17A. Review by the district court shall be an original hearing before the district court.

These rules are intended to implement Iowa Code chapter 249F as amended by 2000 Iowa Acts, chapter 1060.

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CHAPTER 90
TARGETED CASE MANAGEMENT

PREAMBLE

These rules define and structure medical assistance targeted case management services provided in accordance with Iowa Code section 225C.20 for Medicaid members with mental retardation, chronic mental illness, or a developmental disability and members eligible for the home- and community-based services (HCBS) children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid members. The service is designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Child" means a person under 18 years of age.

"Chronic mental illness" means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Major incident" means an occurrence involving a member using the service that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; or
2. Results in a member's death or the death of another person; or
3. Requires emergency mental health treatment for the member; or
4. Requires the intervention of law enforcement; or
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3."
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in 42 Code of Federal Regulations 435.1009, as amended to October 1, 2001. A residential care facility is not a medical institution.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Mental retardation" means a diagnosis of mental retardation which:

1. Is made only when the onset of the person's condition was before the age of 18 years;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a person may share a residence.

"Targeted case management" means services furnished to assist members who are part of a targeted population and who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of mental retardation, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS mental retardation waiver or HCBS children's mental health waiver services according to 441—Chapter 83.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.2(249A) Eligibility. A person who meets all of the following criteria shall be eligible for targeted case management:

90.2(1) The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).

90.2(2) The person is a member of the targeted population.

90.2(3) The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.5(3).

90.2(4) The person has applied for targeted case management in accordance with the policies of the provider.

90.2(5) The person's need for targeted case management has been determined in accordance with rule 441—90.3(249A).
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.3(249A) Determination of need for service.

90.3(1) *Authorization required.* Rescinded IAB 7/15/09, effective 7/1/09.

90.3(2) *Need for service.* Assessment of the need for targeted case management is required at least annually as a condition of payment under the medical assistance program. The case management provider shall determine the initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The member has a need for targeted case management to manage needed medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member.

b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The member is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

90.3(3) *Managed health care.* For members receiving targeted case management under the Iowa plan for behavioral health as described in 441—Chapter 88, Division IV, the department delegates authorization and determination of need for service to the Iowa plan contractor.

a. The Iowa plan contractor shall determine the need for targeted case management services according to the criteria in subrule 90.3(2).

b. The Iowa plan contractor is not required to pay for targeted case management services that it has not authorized or that are provided during a month of Medicaid ineligibility.

90.3(4) *Transition authorization.* Rescinded IAB 7/15/09, effective 7/1/09.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.4(249A) Application. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services are needed or requested.

90.4(1) *Application process and documentation.* The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. The provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

90.4(2) *Application decision.* The provider shall inform the applicant or the applicant's legally authorized representative of any decision to approve, deny, or delay the service in accordance with notification requirements at 441—subrule 7.7(1).

90.4(3) *Delayed services.* The application shall be approved and the member put on the referral list for assignment to a case manager when targeted case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

90.4(4) *Denying applications.* The provider shall deny applications for service when:

a. The applicant is not currently eligible for Medicaid; or

b. The applicant does not meet the eligibility criteria in rule 441—90.2(249A); or

c. The applicant or the applicant's legally authorized representative withdraws the application; or

d. The applicant does not provide information required to process the application; or

e. The applicant is receiving targeted case management from another Medicaid provider; or

f. The applicant does not have a need for targeted case management.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.5(249A) Service provision.

90.5(1) *Covered services.* The following shall be included in the assistance that case managers provide to members in obtaining services:

a. Assessment. The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

(1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating the history annually.

(2) Identifying the needs of the member and completing related documentation.

(3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.

b. Service plan. The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:

(1) Document the parties participating in the development of the plan.

(2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.

(3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.

(4) Document services identified to meet the needs of the member which the member declined to receive.

(5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:

1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.

2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan:

- After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or
- After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

(6) Include a discharge plan.

(7) Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and related activities. The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. *Monitoring and follow-up.* The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.

(2) The member has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.

(5) There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. *Contacts.* Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. E-mail contacts are allowed only when other means of communication are not feasible for the member, representative or family and the necessity for E-mail communication is documented in the member's comprehensive service plan. A copy of any written communication must be maintained in the case file. When E-mail communication is used, there must be clear two-way communication in the member's record showing an exchange of information as well as follow-up activity related to the information.

(3) The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

2. The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

90.5(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service, including but not limited to assertive community treatment (ACT).

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs.

(2) Public guardianship programs.

(3) Special education programs.

(4) Child welfare and child protective services.

(5) Foster care programs.

c. The activities are integral to the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.
(4) Serving legal papers.
(5) Home investigations.
(6) Providing transportation.
(7) Administering foster care subsidies.
(8) Making placement arrangements.

d. The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

90.5(3) *Transition to a community setting.* Case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management under a targeted population. Transitional case management is not an allowable service under the HCBS brain injury waiver, the HCBS elderly waiver, or HCBS habilitation services.

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning.

c. The amount, duration, and scope of case management services shall be documented in the member's plan of care, which must include case management services before and after discharge, to facilitate a successful transition to community living.

d. Payment shall be made only for services provided by community case management providers.

e. Claims for reimbursement for case management shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

90.5(4) *Rights restrictions.* Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes:

a. Documentation of why there is a need for the restriction;

b. A plan to restore those rights or a reason why restoration is not necessary or appropriate; and

c. Documentation that periodic evaluations of the restriction are conducted to determine continued need.

90.5(5) *Documentation.* Service documentation shall also meet the requirements set forth in rule 441—79.3(249A) and 441—subrule 24.4(4).

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9588B**, IAB 6/29/11, effective 9/1/11]

441—90.6(249A) Terminating services.

90.6(1) Targeted case management shall be terminated when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A); or

b. The member has achieved all goals and objectives of the service; or

c. The member has no current need for targeted case management; or

d. The member receiving targeted case management based on eligibility under an HCBS waiver is no longer eligible for the waiver; or

e. The member or the member's legally authorized representative requests termination; or

f. The member is unwilling or unable to accept further services; or

g. The member or the member's legally authorized representative fails to provide access to information necessary for the development of the service plan or implementation of targeted case management.

90.6(2) The provider shall notify the member or the member's legally authorized representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.7(249A) Appeal rights.

90.7(1) *Appeal to the provider.* After notice of an adverse decision by the provider of targeted case management, the member or the member's representative may request an appeal as provided in the appeal process established by the provider agency.

90.7(2) *Appeal to the department.* After notice of an adverse decision by the department pertaining to authorization and need for service, the member or the member's representative may request reconsideration by the department by sending a letter to the department not more than 30 days after the date of the notice of adverse decision. The member or the member's representative may appeal an adverse reconsideration decision by the department as provided in 441—Chapter 7.

90.7(3) *Appeal to the managed health care contractor.* After notice of an adverse decision by a managed health care plan, the member or the member's representative may request a review as provided in rule 441—88.68(249A).

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.8(249A) Provider requirements.

90.8(1) *Incident reporting.*

a. When a major incident occurs during the provision of case management services:

(1) The case management provider shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The case management supervisor.
2. The member's legally authorized representative.

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all case management staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
5. The action that the case manager took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) The case manager shall monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager.

(5) The case managment provider shall maintain the completed report in a centralized file, with a notation in the member's file.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the comprehensive assessment as required in paragraph 90.5(1)*"a"* in order to ensure the continued health, safety, and welfare of the member.

90.8(2) *Emergency coverage.* Rescinded IAB 6/29/11, effective 9/1/11.

90.8(3) *Quality assurance.* Providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

a. Postpayment reviews of case management services,

b. Review of incident reports,

c. Review of reports of abuse or neglect, and

d. Technical assistance in determining the need for service.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9588B**, IAB 6/29/11, effective 9/1/11]

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

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[1] January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.

CHAPTER 91
MEDICARE DRUG SUBSIDY

PREAMBLE

Public Law 108-173, the Medicare Modernization Act of 2003, created a prescription drug benefit for Medicare beneficiaries (Medicare Part D) and a subsidy to reduce or eliminate costs associated with the Medicare drug benefit for persons with limited income and resources. The Act requires both the federal Social Security Administration and state Medicaid agencies to accept and adjudicate subsidy applications. The Social Security Administration refers to the subsidy as "extra help for Medicare prescription drug costs." This chapter implements procedures for the department of human services, the state Medicaid agency in Iowa, to carry out these duties.

441—91.1(249A) Definitions. As used in this chapter:

"Applicant" means a person applying for a Medicare drug subsidy through the department and includes a responsible person or authorized representative acting for an applicant, except for the purposes of subrule 91.2(2).

"Application" or *"Medicare drug subsidy application"* means the federal Social Security Administration's Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs, accompanied by the department's Form 470-4159, Authorization for Department to Process.

"Authorized representative" means a person representing an applicant or recipient as described in 441—paragraph 76.1(7)*"b."*

"Department" means the Iowa department of human services and includes any local office of the department.

"Local office" means a department office as described in 441—subrule 1.4(2).

"Recipient" means a person receiving a Medicare drug subsidy based on an application filed with the department and includes a responsible person or authorized representative acting for a recipient, except for the purposes of subrule 91.2(2).

"Responsible person" means a person acting on an applicant's or recipient's behalf as described at 441—paragraph 76.1(7)*"a."*

441—91.2(249A) Application. Any person may apply for the Medicare drug subsidy through the department.

91.2(1) *Date, method, and place of filing.* An application is considered filed on the date an identifiable signed application is received and date-stamped in any local office.

a. When an application is delivered to a closed local office, the application 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. A copy of an application received by fax shall be given the same effect as the original application.

91.2(2) *Identifiable application and signature.*

a. An identifiable application is an application that contains:

(1) The legible name and address of the applicant; and

(2) The signature of the applicant, a responsible person, or an authorized representative on both Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs, and Form 470-4159, Authorization for Department to Process.

b. If an authorized representative signed the application forms on behalf of an applicant, the applicant or a responsible person must also sign the application forms before the application can be approved.

91.2(3) *Right to withdraw.* After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination.

a. 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.

b. The local office shall send a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, to the applicant confirming the request to withdraw the application.

441—91.3(249A) Eligibility determination. The department shall determine eligibility for the Medicare drug subsidy pursuant to Section 1860D-14 of the Social Security Act and implementing federal regulations at 20 CFR Part 418. The department shall base decisions with respect to initial and ongoing eligibility primarily on information furnished by the applicant or recipient.

91.3(1) *Cooperation.* An applicant must cooperate with the department in the application process. Cooperation may include providing additional information or verification of information, participating in an interview, or signing documents. Failure to cooperate in the application process shall be a basis for denial of an application.

91.3(2) *Additional information and verification.* The department shall notify the applicant or recipient in writing of any additional information or verification that is required to maintain or establish eligibility. This notice shall be delivered to the applicant or recipient by personal delivery, mail, or facsimile transmission.

a. The applicant or recipient shall have five working days to supply the information or verification requested by the department. The local office may extend the deadline for a reasonable period when the applicant or recipient is making every effort to secure the required information or verification from a third party but has been unable to do so.

b. Failure of the applicant or recipient to supply the information or verification, or refusal by the applicant or recipient to authorize the department to secure the information or verification from other sources, shall serve as a basis for denial of an application or cancellation or reduction of the Medicare drug subsidy.

91.3(3) *Interviews.* At the discretion of the local office, an interview with the applicant or recipient may be required when processing the initial application or at the time of any review of eligibility.

a. The department shall notify the applicant or recipient in writing of the date, time, and method of any required interview. This notice shall be delivered to the applicant or recipient by personal delivery, mail, or facsimile transmission. Interviews may be rescheduled at the request of the applicant or recipient without written notice.

b. Failure of the applicant or recipient to participate in a scheduled interview shall serve as a basis for denial of an application or cancellation or reduction of the Medicare drug subsidy.

441—91.4(249A) Notice of decision. The department shall notify the applicant or recipient in writing of any decision regarding the applicant's or recipient's subsidy eligibility or level of subsidy.

91.4(1) The department shall issue a written notice of decision to an applicant by the next working day following a determination of subsidy eligibility and level of subsidy.

91.4(2) The department shall give a recipient timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is taken that adversely affects subsidy eligibility or the level of subsidy.

91.4(3) In the circumstances described in 441—subrule 7.7(2), the department may dispense with timely notice but shall send adequate notice no later than the effective date of action.

441—91.5(249A) Effective date. A Medicare prescription drug subsidy shall be effective beginning with the first day of the month of application or the first day of the first month in which all eligibility requirements are met, whichever is later, but no earlier than January 1, 2006.

441—91.6(249A) Changes in circumstances.

91.6(1) *Responsibility to report changes.* A Medicare drug subsidy applicant or recipient shall timely report to the department any changes in the following circumstances:

a. Care of dependents.

b. Household composition.

c. Household income.

d. Household resources.
e. Marital status.
f. Medicare eligibility or enrollment.
g. Place of residence.

91.6(2) *Timely report.* A report shall be considered timely when received in the local office within ten days from the date the change is known to a recipient and within five days from the date the change is known to an applicant.

91.6(3) *Effective date of change.* Changes in eligibility or level of subsidy shall be effective the month following the month in which the change is reported.

441—91.7(249A) Reinvestigation. The department shall reinvestigate eligibility as often as the recipient's circumstances indicate, but in no instance shall the period between reinvestigations exceed 12 months.

91.7(1) *Application requested.* When requested to do so by the department, the recipient shall complete the Medicare drug subsidy application as part of the reinvestigation process. The application shall be completed within five working days from the date a written request is issued. Failure to complete the application shall be a basis for cancellation or reduction of the subsidy.

91.7(2) *Additional information requested.* The recipient shall supply additional information needed to establish eligibility or level of subsidy within five working days from the date a written request is issued.

a. The recipient shall give written permission for the release of information when the recipient is unable to furnish information needed to establish eligibility.

b. Failure to supply requested information or authorize the department to secure the information from other sources shall be a basis for cancellation or reduction of the subsidy.

441—91.8(249A) Appeals. An applicant or recipient shall have the right to appeal any adverse action by the department regarding the Medicare drug subsidy, pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code sections 217.6 and 249A.4 and Section 1935(a) of the Social Security Act (42 U.S.C. § 1396u-5).

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CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Indian" means a Native American eligible, as an Indian, to receive health care services from an Indian health care provider as defined in this rule.

"Indian health care provider" means a health care program operated by the Indian Health Service of the U.S. Department of Health and Human Services or by an Indian tribe, tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. § 1603.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code section 249J.6.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 0760C**, IAB 5/29/13, effective 5/8/13]

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member's group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

[**ARC 8505B**, IAB 2/10/10, effective 4/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) and has income over 150 percent of the federal poverty level shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department's request.

92.3(2) A new application is required for each certification period.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9982B**, IAB 2/8/12, effective 4/1/12]

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

c. If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.*

a. A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

b. Persons income-eligible on June 30, 2013, shall remain income-eligible through December 31, 2013, regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

[**ARC 0862C**, IAB 7/24/13, effective 7/1/13; **ARC 1059C**, IAB 10/2/13, effective 11/6/13]

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

a. For women and newborns eligible under 92.2(1)*"b"* or *"c,"* the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

92.6(4) *Reinstatement.* Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

92.6(5) *Extension of certifications from June 30, 2013.* Any certification period in effect June 30, 2013, shall continue until December 31, 2013.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 0862C**, IAB 7/24/13, effective 7/1/13; **ARC 1059C**, IAB 10/2/13, effective 11/6/13]

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c"* and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Subject to the annual update pursuant to paragraph 92.7(1)*"b,"* for certification periods beginning on or after April 1, 2013, premiums are as follows:

When there is one IowaCare member in the household and the household's income is at or below:	The member's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$52
170% of federal poverty level	$56
180% of federal poverty level	$59
190% of federal poverty level	$62
200% of federal poverty level	$66

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$70
170% of federal poverty level	$74
180% of federal poverty level	$79
190% of federal poverty level	$83
200% of federal poverty level	$87

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. *Method of payment.* Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. *Due date.* When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. *Application of payment.* The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."*

a. If the statement is not received by five working days after the premium due date, the member or household shall be obligated to pay the premium.

b. If the statement is timely submitted with a partial payment, exemption shall be granted for the balance owed for that month.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

(1) Two calendar months after eligibility ended unless an application or reapplication is pending, or

(2) Upon the person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

(1) After two calendar months of a zero premium, or

(2) Upon the member's request.

[**ARC 7667B**, IAB 4/8/09, effective 4/1/09; **ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9532B**, IAB 6/1/11, effective 7/6/11; **ARC 9982B**, IAB 2/8/12, effective 4/1/12; **ARC 0151C**, IAB 6/13/12, effective 7/18/12; **ARC 0759C**, IAB 5/29/13, effective 5/8/13]

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through 92.8(7), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13); or

e. An Indian health care provider enrolled in the IowaCare program, for services provided to Indians.

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics or when provided by an Indian health care provider to an Indian.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1)*"c."* Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

92.8(6) *Medical home.* As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) other than Indian health care providers must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

(4) Provide wellness and disease prevention services.

(5) Create and maintain chronic disease information in a searchable disease registry.

(6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall assign the member to that provider. If an IowaCare member who is assigned to a medical home and who is not an Indian chooses to go to another provider without a referral from the medical home:

(1) The service is not covered by the IowaCare program, and

(2) The provider may bill the member according to the provider's established criteria for billing other patients.

d. Subject to subrule 92.8(1), services provided to Indians assigned to a medical home may be covered by the IowaCare program if:

(1) Provided by the assigned medical home or pursuant to a referral by the assigned medical home; or

(2) Provided by an Indian health care provider enrolled in the IowaCare program or pursuant to a referral by an Indian health care provider enrolled in the IowaCare program.

92.8(7) *Services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services.

b. If the conditions listed in paragraph *"a"* are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

c. Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.
2. Home health services.
3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.
2. Air compressors.
3. Bedside commodes.
4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7)*"c"*(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.
20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

d. Laboratory tests and radiology services. Payment will be made to federally qualified health centers, as part of the per-IowaCare-patient-encounter payment made pursuant to 92.9(3)*"b,"* for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by the federally qualified health center.

92.8(8) *Referral protocols.* When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

a. By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

b. After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

92.8(9) *Other services provided by Broadlawns Medical Center.* Broadlawns Medical Center shall be reimbursed for outpatient prescription drugs, podiatry services, optometric services, and durable medical equipment provided to members of the expansion population. Payment is limited to the amount of funds appropriated for this purpose.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9728B**, IAB 9/7/11, effective 9/1/11; **ARC 9890B**, IAB 11/30/11, effective 1/4/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0200C**, IAB 7/11/12, effective 7/1/12; **ARC 0760C**, IAB 5/29/13, effective 5/8/13; **ARC 1072C**, IAB 10/2/13, effective 10/1/13]

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) *Claims.* Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) *Payment for hospital services provided by IowaCare network.* Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) *Payment for nonhospital services provided by IowaCare network.* Effective January 1, 2013, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts, which are posted on the department's Web site at http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Services provided to IowaCare members by a federally qualified health center, including any medically necessary laboratory tests and radiology services authorized by the federally qualified health center, shall be reimbursed on the basis of a per-IowaCare-patient-encounter payment calculated for each participating federally qualified health center as follows:

(1) The initial encounter rates will be based on the total fees paid to the federally qualified health center under the IowaCare program for dates of service from July 1, 2012, through December 31, 2012 (the "initial rate period"), plus the total fees paid to third parties for laboratory and diagnostic services referred out from the particular federally qualified health center during the initial rate period. The rates shall exclude any fees charged by or through the University of Iowa Hospitals and Clinics or Broadlawns Medical Center or through any other federally qualified health center.

(2) The initial encounter rates will be reevaluated on or after April 15, 2013. If the reevaluation results in changes in the initial encounter rate, the department will mass-adjust all of the federally qualified health center's claims submitted for dates of service from January 1, 2013, through March 31, 2013.

(3) After the first quarter of calendar year 2013, the department shall establish a new encounter rate for the federally qualified health center following the end of the prior quarter, based on claims submitted for the prior quarter.

(4) The department shall reevaluate each new encounter rate 45 days after the start of each quarter to consider adjustments based on laboratory and diagnostic claims received with dates of service from the prior quarter submitted within the prior 45 days. If the reevaluation results in changes in the current encounter rate, the department will change the current encounter rate retroactively for the quarter and mass-adjust any claims submitted for the current quarter.

(5) Upon expiration or termination of the IowaCare medical home agreement, the department will reevaluate the encounter rate paid to the federally qualified health center in the final whole or partial quarter by taking into consideration any laboratory and diagnostic claims submitted within 45 days of the expiration or termination of the agreement with dates of service from that final quarter. If the reevaluation results in changes in that final quarter's encounter rate, the department will change the encounter rate for the final quarter and mass-adjust any prior claims submitted for that final quarter.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) *Medical home payments.*

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than $4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) *Payment for services provided by nonparticipating hospitals.* Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) *Payment for services provided by other nonparticipating providers.* Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 1072C**, IAB 10/2/13, effective 10/1/13]

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.

2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).

3. The member does not pay premiums as required by 441—92.7(249A,249J).

4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).

5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.

6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.*

a. To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

b. As required by the waiver of Title XIX requirements allowing for federal funding of the IowaCare program, and based on available funding for the 2013-2014 state fiscal year, enrollment of new members in IowaCare will be suspended for applications filed on or after July 1, 2013.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

[**ARC 0862C**, IAB 7/24/13, effective 7/1/13; **ARC 1059C**, IAB 10/2/13, effective 11/6/13]

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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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 participant households to PROMISE JOBS pursuant to 441—subrule 41.24(4).

93.3(3) *Initial appointment.*

a. FIP applicants. FIP applicants, including those who are in a limited benefit plan, shall be offered an appointment with the PROMISE JOBS provider agency for assessment and FIA development at the earliest available time. The provider agency shall make sufficient appointment times available to allow the applicant to be scheduled 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."*

b. Exempt status change. Persons who become FIA-responsible while receiving FIP shall initiate PROMISE JOBS orientation and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the letter explaining that exempt status has been lost and FIA responsibility has begun, as required by 441—subrule 41.24(5). If the person fails to schedule an appointment or fails to appear for an appointment, PROMISE JOBS shall send one written reminder that informs the person that those who do not develop a family investment agreement shall enter into a limited benefit plan. If the person fails to schedule an appointment within ten calendar days of the reminder letter or fails to appear for an appointment scheduled after the reminder is sent, the person shall enter into a limited benefit plan as described at 441—paragraph 41.24(8)*"c."*

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.

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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—paragraphs 41.24(4)*"a," "b"* and *"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.
[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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 all participants,yyoj8893 particularly those who have recent ties with the workforce, have successfully removed or reduced barriers to work, or have completed job club or training and are now ready to work. If after three calendar months the participant still has not found employment, the worker shall review the participant's situation for possible barriers to employment or possible need for training to increase the participant's employability. Job search may continue if appropriate, but linking with other activities should be considered.

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 within the same calendar month 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.

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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. Inclusion of family development services by participants as a family investment agreement activity is voluntary except for unmarried parents aged 17 and younger who do not live with a parent or legal guardian 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.

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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 verified by the PROMISE JOBS worker. The participant shall provide Form 470-3099, Job Search Record, within ten calendar days following the end of each month 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).

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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.

[**ARC 8346B**, IAB 12/2/09, effective 12/1/09; **ARC 8557B**, IAB 3/10/10, effective 4/14/10]

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). 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 when the participant does not have a problem or barrier to participation as defined at paragraph 93.4(5)*"a"* or rule 441—93.14(239B) 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 and other work activity issues. Participants who do not follow up on job referrals, who refuse offers of employment or other work activity, who reduce hours of employment or other work activity, who terminate employment or other work activity, or who are discharged from employment or other work activity 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 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).

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14; **ARC 1208C**, IAB 12/11/13, effective 2/1/14]

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. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

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. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

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."*

[**ARC 1146C**, IAB 10/30/13, effective 1/1/14]

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 94
IOWA TRANSITIONAL ASSISTANCE FOR DIRECT EDUCATION COSTS PROGRAM

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TITLE X
SUPPORT RECOVERY

CHAPTER 95
COLLECTIONS

[Prior to 7/1/83, Social Services[770] Ch 95]
[Prior to 2/11/87, Human Services[498]]

441—95.1(252B) Definitions.

"Bureau chief" shall mean the chief of the bureau of collections of the department of human services or the bureau chief's designee.

"Caretaker" shall mean a custodial parent, relative or guardian whose needs are included in an assistance grant paid according to Iowa Code chapter 239B, or who is receiving this assistance on behalf of a dependent child, or who is a recipient of nonassistance child support services.

"Child support recovery unit" shall mean any person, unit, or other agency which is charged with the responsibility for providing or assisting in the provision of child support enforcement services pursuant to Title IV-D of the Social Security Act.

"Consumer reporting agency" shall mean any person or organization which, for monetary fees, dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports.

"Current support" shall mean those payments received in the amount, manner and frequency as specified by an order for support and which are paid to the clerk of the district court, the public agency designated as the distributor of support payments as in interstate cases, or another designated agency. Payments to persons other than the clerk of the district court or other designated agency do not satisfy the definition of support pursuant to Iowa Code section 598.22. In addition, current support shall include assessments received as specified pursuant to rule 441—156.1(234).

"Date of collection" shall mean the date that a support payment is received by the department or the legal entity of any state or political subdivision actually making the collection, or the date that a support payment is withheld from the income of a responsible person by an employer or other income provider, whichever is earlier.

"Delinquent support" shall mean a payment, or portion of a payment, including interest, not received by the clerk of the district court or other designated agency at the time it was due. In addition, delinquent support shall also include assessments not received as specified pursuant to rule 441—156.1(234).

"Department" shall mean the department of human services.

"Dependent child" shall mean a person who meets the eligibility criteria established in Iowa Code chapter 234 or 239B, and whose support is required by Iowa Code chapter 234, 239B, 252A, 252C, 252F, 252H, 252K, 598 or 600B, and any other comparable chapter.

"Federal nontax payment" shall mean an amount payable by the federal government which is subject to administrative offset for support under the federal Debt Collection Improvement Act, Public Law 104-134.

"Obligee" shall mean any person or entity entitled to child support or medical support for a child.

"Obligor" shall mean a parent, relative or guardian, or any other designated person who is legally liable for the support of a child or a child's caretaker.

"Payor of income" shall have the same meaning provided this term in Iowa Code section 252D.16.

"Prepayment" shall mean payment toward an ongoing support obligation when the payment exceeds the current support obligation and amounts due for past months are fully paid.

"Public assistance" shall mean assistance provided according to Iowa Code chapter 239B or 249A, the cost of foster care provided by the department according to chapter 234, or assistance provided under comparable laws of other states.

"Responsible person" shall mean a parent, relative or guardian, or any other designated person who is or may be declared to be legally liable for the support of a child or a child's caretaker. For the purposes of calculating a support obligation pursuant to the mandatory child support guidelines prescribed by the

Iowa Supreme Court in accordance with Iowa Code section 598.21B, this shall mean the person from whom support is sought.

"Support" shall mean child support or medical support or both for purposes of establishing, modifying or enforcing orders, and spousal support for purposes of enforcing an order.

This rule is intended to implement Iowa Code chapters 252B, 252C and 252D.

[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—95.2(252B) Child support recovery eligibility and services.

95.2(1) *Public assistance cases.* The child support recovery unit shall provide paternity establishment and support establishment, modification and enforcement services, as appropriate, under federal and state laws and rules for children and families referred to the unit who have applied for or are receiving public assistance. Referrals under this subrule may be made by the family investment program, the Medicaid program, the foster care program or agencies of other states providing child support services under Title IV-D of the Social Security Act for recipients of public assistance.

95.2(2) *Nonpublic assistance cases.* The same services provided by the child support recovery unit for public assistance cases shall also be made available to any person not otherwise eligible for public assistance. The services shall be made available to persons upon the completion and filing of an application with the child support recovery unit except that an application shall not be required to provide services to the following persons:

a. Persons not receiving public assistance for whom an agency of another state providing Title IV-D child support recovery services has requested services.

b. Persons for whom a foreign reciprocating country or a foreign country with which this state has an arrangement as provided in 42 U.S.C. §659 has requested services.

c. Persons who are eligible for continued services upon termination of assistance under the family investment program or Medicaid.

95.2(3) *Services available.* Except as provided by separate rule, the child support recovery unit shall provide the same services as the unit provides for public assistance recipients to persons not otherwise eligible for services as public assistance recipients. The child support recovery unit shall determine the appropriate enforcement procedure to be used. The services are limited to the establishment of paternity, the establishment and enforcement of child support obligations and medical support obligations, and the enforcement of spousal support orders if the spouse is the custodial parent of a child for whom the department is enforcing a child support or medical support order.

95.2(4) *Application for services.*

a. A person who is not on public assistance requesting services under this chapter, except for those persons eligible to receive support services under paragraphs 95.2(2)*"a," "b,"* and *"c,"* shall complete and return Form 470-0188, Application for Nonassistance Support Services, for each parent from whom the person is seeking support.

(1) The application shall be returned to the child support recovery unit serving the county where the person resides. If the person does not live in the state, the application form shall be returned to the county in which the support order is entered or in which the other parent or putative father resides.

(2) The person requesting services has the option to seek support from one or both of the child's parents.

b. An individual who is required to complete Form 470-0188, Application for Nonassistance Support Services, shall be charged an application fee in the amount set by statute. The unit shall charge one application fee for each parent from whom support is sought. The unit shall charge the fee at the time of initial application and any subsequent application for services. The individual shall pay the application fee to the local child support recovery unit before services are provided.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4.

441—95.3(252B) Crediting of current and delinquent support. The amounts received as support from the obligor shall be credited as the required support obligation for the month in which they are collected. Any excess shall be credited as delinquent payments and shall be applied to the immediately preceding

month, and then to the next immediately preceding month until all excess has been applied. Funds received as a result of federal tax offsets shall be credited according to rule 441—95.7(252B).

The date of collection shall be determined as follows:

95.3(1) *Payments from income withholding.* Payments collected as the result of income withholding are considered collected in the month in which the income was withheld by the income provider. The date of collection shall be the date on which the income was withheld.

a. For the purpose of reporting the date the income was withheld, the department shall notify income providers of the requirement to report the date income was withheld and shall provide Form 470-3221, "Income Withholding Return Document," to those income providers who manually remit payments. When reported on this form or through other electronic means or multiple account listings, the date of collection shall be used to determine support distributions. When the date of collection is not reported, support distributions shall initially be issued based on the date of the check. If proof of the date of collection is subsequently provided, any additional payments due the recipient shall be issued.

b. When the collection services center (CSC) is notified or otherwise becomes aware that a payment received from an income provider pursuant to 441—Chapter 98, Division II, includes payment amounts such as vacation pay or severance pay, these amounts are considered irrevocably withheld in the months documented by the income provider. When the income provider does not document the months for which the sums are withheld, the amounts shall initially be distributed based on the date of the check. If documentation is subsequently provided, any additional payments due the recipient shall be issued.

95.3(2) *Payments from state or political subdivisions.* Payments collected from any state or political subdivision are considered collected in the same month the payments were actually received by that legal entity or the month withheld by an income provider, whichever is earlier. Any state or political subdivision transmitting payments to the department shall be responsible for reporting the date the payments were collected. When the date of collection is not reported, support distributions shall be initially issued based on the date of the state's or political subdivision's check. If proof of the date of collection is subsequently provided, any additional payments due the recipient shall be issued.

95.3(3) *Additional payments.* An additional payment in the month which is received within five calendar days prior to the end of the month shall be considered collected in the next month if:

a. CSC is notified or otherwise becomes aware that the payment is for the next month, and

b. Support for the current month is fully paid.

This rule is intended to implement Iowa Code sections 252B.15 and 252D.17.

441—95.4(252B) Prepayment of support. Prepayment which is due to the child support obligee shall be sent to the obligee upon receipt by the department, and shall be credited as payment of future months' support. Prepayment which is due the state shall be distributed as if it were received in the month when due. Support is prepaid when amounts have been collected which fully satisfy the ongoing support obligation for the current month and all past months.

441—95.5(252B) Lump sum settlement.

95.5(1) Any lump sum settlement of child support involving an assignment of child support payments shall be negotiated in conjunction with the child support recovery unit. The child support recovery unit shall be responsible for the determination of the amount due the department, including any accrued interest on the support debt computed in accordance with Iowa Code section 535.3 for court judgments. This determination of the amount due shall be made in accordance with Section 302.51, Code of Federal Regulations, Title 45 as amended to August 4, 1989. The bureau chief may waive collection of the accrued interest when negotiating a lump sum settlement of a support debt, if the waiver will facilitate the collection of the support debt.

95.5(2) The child support recovery unit shall be responsible for the determination of the department's entitlement to all or any of the lump sum payment in a paternity action.

This rule is intended to implement Iowa Code chapter 252C.

441—95.6(252B) Offset against state income tax refund or rebate. The department will make a claim against an obligor's state income tax refund or rebate when a support payment is delinquent as set forth in 11—Chapter 40. A claim against an obligor's state income tax refund or rebate shall apply to support which the department is attempting to collect.

95.6(1) By the first day of each month, the department shall submit to the department of administrative services a list of obligors who are delinquent at least $50 in support payments.

95.6(2) When the department claims an obligor's state income tax refund or rebate, the department shall send a preoffset notice to the obligor to inform the obligor of the amount the department intends to claim and apply to support. The department shall send a preoffset notice when:

a. The department of administrative services notifies the department that the obligor is entitled to a state income tax refund or rebate; and

b. The obligor has a delinquency of $50 or greater.

95.6(3) When the obligor wishes to contest a claim, a written request shall be submitted to the department within 15 days after the preoffset notice is sent. When the request is received within the 15-day limit, a hearing shall be granted pursuant to rules in 441—Chapter 7.

95.6(4) The spouse's proportionate share of a joint return filed with an obligor, as determined by the department of revenue, shall be released by the department of revenue unless other claims are made on that portion of the joint income tax refund. The request for release of a spouse's proportionate share shall be received by the department within 15 days after the date of the preoffset notice.

95.6(5) The department shall refund any amount incorrectly offset to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

95.6(6) The department shall notify an obligor of the final decision regarding the claim against the tax refund or rebate by sending a final disposition of support recovery claim notice to the obligor.

95.6(7) Application of offset. Offsets shall be applied as provided in rule 441—95.3(252B).

This rule is intended to implement Iowa Code sections 8A.504, 252B.3, 252B.4 and 252B.5(4).

[**ARC 9177B**, IAB 11/3/10, effective 1/1/11]

441—95.7(252B) Offset against federal income tax refund and federal nontax payment. The department will make a claim against an obligor's federal income tax refund or federal nontax payment when delinquent support is owed. For purposes of this offset, delinquent support shall include the entire balance of a judgment for accrued support, as provided in Iowa Code section 252B.5(4).

95.7(1) Amount of assigned support. If the delinquent support is assigned to the department, the amount of delinquent support shall be at least $150, calculated by combining the assigned delinquent support in all of the obligor's cases in which the assigned delinquent support is at least $50.

95.7(2) Amount of nonassigned support. If delinquent support is not assigned to the department, the claim shall be made if the amount of delinquent support is at least $500, calculated by combining the nonassigned delinquent support in all of the obligor's cases in which the nonassigned delinquent support is at least $50.

a. The amount distributed to an obligee shall be the amount remaining following payment of a support delinquency assigned to the department. The department shall distribute to an obligee the amount collected from an offset according to subrule 95.7(9) within the following time frames:

(1) Within six months from the date the department applies an offset amount from a joint income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 95.7(8), whichever is later, or

(2) Within 30 days from the date the department applies an offset amount from a single income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 95.7(8), whichever is later.

(3) However, the department is not required to distribute until it has received the amount collected from an offset from the federal Department of the Treasury.

b. Federal nontax payment offset distribution. Federal nontax payment offsets shall be applied as provided in rule 441—95.3(252B).

95.7(3) Notification to federal agency. The department shall, by October 1 of each year or at times as permitted or specified by federal regulations, submit a notification(s) of liability for delinquent support to the federal office of child support enforcement.

95.7(4) Preoffset notice and review. Each obligor who does not have an existing support debt on record with the federal office of child support enforcement will be sent a preoffset notice in writing, using address information provided to the federal office of child support enforcement, stating the amount of the delinquent support certified for offset.

a. Individuals whose names were submitted for federal offset who wish to dispute the offset must notify the department in writing within the time period specified in the preoffset notice.

b. Upon receipt of a complaint from the individual disputing the submission for offset, the child support recovery unit shall conduct a review to determine if there is a mistake of fact and respond to the individual in writing within ten days. For purposes of this rule, "mistake of fact" means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral.

95.7(5) Recalculation of delinquency. When the records of the department differ with those of the obligor for determining the amount of the delinquent support, the obligor may provide and the department will accept documents verifying modifications of the order, and records of payments made pursuant to state law, and will recalculate the delinquency.

95.7(6) The department shall notify the federal office of child support enforcement, within time frames established by it, of any modification or elimination of an amount referred for offset.

95.7(7) When an individual does not respond to the preoffset notice within the specified time even though the department later agrees a certification error was made, the person must wait for corrective action as specified in subrule 95.7(8).

95.7(8) Offset notice, appeal, and refund. The federal Department of the Treasury will send notice that a federal income tax refund or federal nontax payment owed to the obligor has been intercepted. When the unit receives information from the federal office of child support enforcement regarding the offset, or when the individual whose name was submitted for federal offset notifies the department that the individual has received an offset notice, the department shall issue to that individual Form 470-3684, Appeal Rights for Federal Offsets.

a. The individual whose name was submitted for federal offset shall have 15 days from the date of the notice to contest the offset by initiating an administrative appeal pursuant to 441—subrules 7.8(1) and 7.8(2). Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 7. The issue on appeal shall be limited to a mistake of fact as specified at paragraph 95.7(4)*"b."*

b. The department shall refund the incorrect portion of a federal income tax offset or federal nontax payment offset within 30 days following verification of the offset amount. Verification shall mean a listing from the federal office of child support enforcement containing the obligor's name and the amount of tax refund or nontax payment to which the obligor is entitled. The date the department receives the federal listing will be the beginning day of the 30-day period in which to make a refund.

c. The department shall refund the amount incorrectly set off to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

95.7(9) Application of offsets. Offsets of federal income tax refunds shall be applied to delinquent support only. The department shall first apply the amount collected from an offset to delinquent support assigned to the department under Iowa Code chapters 234 and 239B. The department shall then apply any amount remaining in equal proportions to delinquent support due individuals receiving nonassistance services.

This rule is intended to implement Iowa Code sections 252B.3, 252B.4, and 252B.5.

[**ARC 9177B**, IAB 11/3/10, effective 1/1/11]

441—95.8(96) Child support offset of unemployment insurance benefits. When the department of workforce development notifies the child support recovery unit that an individual who owes a child support obligation being enforced by the unit has been determined to be eligible for unemployment insurance benefits, the unit will enforce a child support obligation that is owed by an obligor but is not

being met by offset of unemployment insurance benefits. "Owed but not being met" means either current child support not being met or arrearages that are owed.

95.8(1) Withholding. The child support recovery unit shall offset unemployment insurance benefits by initiating a withholding of income pursuant to Iowa Code chapter 252D and 441—Chapter 98, Division II. The amount to be withheld through a withholding of unemployment insurance benefits shall not exceed the amount specified in 15 U.S.C. 1673(b).

95.8(2) A receipt of the payments intercepted through unemployment insurance benefits will be provided once a year, upon the obligor's request to the child support recovery unit.

This rule is intended to implement Iowa Code section 96.3 and 15 U.S.C. 1673(b).

441—95.9 Reserved.

441—95.10(252C) Mandatory assignment of wages. Rescinded IAB 9/5/90, effective 11/1/90.

441—95.11(252C) Establishment of an administrative order. Rescinded IAB 9/1/93, effective 11/1/93. See 441—99.41(252C).

441—95.12(252B) Procedures for providing information to consumer reporting agencies. The bureau chief shall make information available to consumer reporting agencies, upon their request, regarding the amount of overdue support owed by a responsible person only in cases where the overdue support exceeds $1,000.

95.12(1) Request of information. Agencies shall request the information from the Bureau of Collections, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114. Requests for information about an individual shall include the individual's name and identifying information such as a social security number or birth date. Agencies may also request a listing of all obligors owing support in excess of $1,000.

95.12(2) A notice of proposed release of information shall be sent to the last known address of the responsible person 30 calendar days prior to the release of the support arrearage information to a consumer reporting agency. This notice shall explain the information to be released and the methods available for contesting the accuracy of the information.

95.12(3) The responsible person may, within 15 calendar days of the date of the notice of proposed release of information, request a conference with the child support recovery officer to contest the accuracy of the information to be given to the consumer reporting agency. In contested cases no referral shall be made to the consumer reporting agency until after the amount of overdue support has been confirmed to exceed $1,000.

95.12(4) Rescinded IAB 11/6/96, effective 1/1/97.

This rule is intended to implement Iowa Code section 252B.8.

441—95.13(17A) Appeals. Nonreceipt of support collected by the department that is to be paid to the obligee may be appealed pursuant to the procedures provided in this rule if the obligee claims that the payment was credited to the incorrect month in accordance with subrules 95.3(1), 95.3(2), and 95.3(3).

95.13(1) *Contact with department.* Obligees who believe they have not received all or part of a support payment to which they are entitled in accordance with subrules 95.3(1), 95.3(2), and 95.3(3) must first contact a customer service representative and indicate that they have not received the payment.

a. An obligee may contact a customer service representative in person at the department's collection services center, by telephone through the specialized customer services unit, or by writing to the Collection Services Center, 727 East 2nd Street, Des Moines, Iowa 50306.

b. The department will acknowledge this contact in writing, indicating the months at issue.

95.13(2) *Written decision.* Within 30 days of the contact, the department shall issue a written decision on all contested support distributions based on the date of collection.

95.13(3) *Initiation of appeal.* If the department denies some or all support payments that are claimed based on the date of collection, the obligee may initiate an administrative appeal.

a. To initiate an administrative appeal, the obligee shall make a written request to the child support recovery unit indicating an intent to appeal.

b. The time limit for initiating an administrative appeal shall be governed by 441—subrule 7.5(4). The time limit provided in 441—subrule 7.5(4) shall start with the date that a written decision as required by subrule 95.13(2) is issued.

c. If no written decision has been issued after 30 days, the obligee may appeal the failure to issue a written decision. The appeal may be initiated at any time after 30 days and before a written decision is issued.

95.13(4) *Limitation of appeals.* Appeals will be limited to claims based on child support received by the department during the nine-month period before the month in which the appeal is initiated.

95.13(5) *Appeal process.* Except as specifically provided in this rule, administrative appeals shall be governed by 441—Chapter 7.

95.13(6) *Appeal issue.* The issue in appeals held pursuant to these procedures shall be limited to the obligee's entitlement to a support payment that has been collected by the department.

This rule is intended to implement Iowa Code sections 17A.12 to 17A.20.

441—95.14(252B) Termination of services.

95.14(1) *Case closure criteria.*

a. Child support services to a recipient of public assistance may be terminated when one of the following case closure criteria is met:

(1) There is no ongoing support obligation and arrearages are under $500 or unenforceable under state law.

(2) The noncustodial parent or putative father is deceased and no further action, including a levy against the estate, can be taken.

(3) Paternity cannot be established because:

1. The child is at least 18 years old and action to establish paternity is barred by the statute of limitations;

2. A genetic test or a court or administrative process has excluded the putative father and no other putative father can be identified; or

3. The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by the child support recovery unit with the recipient of services.

(4) The noncustodial parent's location is unknown, and the child support recovery unit has made diligent efforts to locate the noncustodial parent using multiple sources, in accordance with regulations in 45 CFR 303.3, as amended to March 10, 1999, all of which have been unsuccessful, within the applicable time frame:

1. Over a three-year period when there is sufficient information to initiate an automated locate effort.

2. Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(5) The noncustodial parent cannot pay support for the duration of the child's minority because the parent has been institutionalized in a psychiatric facility, is incarcerated with no chance for parole, or has a medically verified total and permanent disability with no evidence of support potential. The child support recovery unit must have determined that no income or assets are available to the noncustodial parent which could be levied or attached for the payment of support.

(6) The noncustodial parent is a citizen of, and lives in, a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets, and there is not a reciprocity agreement with that country.

(7) There has been a finding of good cause or other exception in a public assistance case as specified in 441—subrules 41.22(8) through 41.22(12) and 441—subrule 75.14(3), including a determination that support enforcement may not proceed without risk or harm to the child or caretaker relative.

(8) The child support recovery unit documents failure by the child support agency of another state which requested services to take an action which is essential for the next step in providing services.

(9) The non-IV-A recipient of services requests closure of a case and there is no assignment to the state of medical support under 42 CFR 433.146, as amended to October 1, 2002, or of arrearages which accrued under a support order.

(10) The case meets any other basis for case closure based upon federal law.

b. Child support services to a person who is not receiving public assistance may be terminated when one of the case closure criteria of subparagraphs 95.14(1)*"a"*(1) through (6) or (8) is met or for one or more of the following reasons:

(1) The child support recovery unit has received a written or oral request from the recipient to close the case, and there is no assignment to the state of medical support or arrearages which accrued under a support order.

(2) The child support recovery unit has received information that the address in the unit's record is no longer current, and the unit is unable to contact or otherwise locate the recipient within 60 days following receipt of this information, despite an attempt of at least one letter sent by first-class mail to the recipient's last-known address.

(3) The recipient of services has failed to cooperate with the child support recovery unit, the circumstances of the noncooperation have been documented, and an action by the recipient of services is essential for the next step in providing services. (See rule 441—95.19(252B).)

(4) The child support recovery unit has provided location-only services.

(5) The child support recovery unit has determined that it would not be in the best interest of the child to establish paternity in a case that involves incest or forcible rape or a case in which legal proceedings for adoption are pending.

(6) The case meets any other basis for case closure based upon federal law.

95.14(2) *Notification in public assistance cases.* In cases meeting one of the criteria of subparagraphs 95.14(1)*"a"*(1) through (6), (8), or (10), the child support recovery unit shall send notification of its intent to close the case to the recipient of services or the child support agency in the state which requested services in writing 60 calendar days before case closure. The notice shall be sent to the recipient of services or the state requesting services at the last-known address stating the reason for denying or terminating services, the effective date, and an explanation of the right to request a hearing according to 441—Chapter 7. Closure of the case following notification is subject to the following:

a. If, in response to the notice, the recipient of services or the state requesting services supplies information which could lead to the establishment of paternity or a support order or enforcement of an order, the case shall be kept open.

b. The recipient of services may request that the case be reopened at a later date if there is a change in circumstances which could lead to the establishment of paternity or a support order or enforcement of an order by completing a new application and paying any applicable fee.

95.14(3) *Reasons for termination of services to nonpublic assistance recipients.* Rescinded IAB 4/30/03, effective 7/1/03.

95.14(4) *Notification in nonpublic assistance cases.* The child support recovery unit shall provide notification to nonpublic assistance cases meeting the criteria for closure in paragraph 95.14(1)*"b"* in the manner and under the conditions stated in subrule 95.14(2), except for cases terminated for the reasons listed in subparagraphs 95.14(1)*"b"*(1) and (4). If the case is to be closed because the child support recovery unit was unable to contact the recipient of services as provided in subparagraph 95.14(1)*"b"*(2), the case shall be kept open if contact is reestablished with the recipient of services before the effective date of the closure.

This rule is intended to implement Iowa Code sections 252B.4, 252B.5 and 252B.6.

441—95.15(252B) Child support recovery unit attorney.

95.15(1) *State's representative.* An assistant attorney general, assistant county attorney, or independent contract attorney employed by or under contract with the child support recovery unit represents only the state of Iowa. The sole attorney-client relationship for the child support recovery

unit attorney is between the attorney and the state of Iowa. A private attorney acting under Iowa Code section 252B.6A is not a child support recovery unit attorney, and is not a party to the action.

95.15(2) *Provision of services.* The special role of the child support recovery unit attorney is limited by the attorney-client relationship between the attorney and the state of Iowa. The provision of legal services by the child support recovery unit attorney is limited as follows:

a. The child support recovery unit attorney shall not represent any person or entity other than the state of Iowa in the course of the attorney's employment by or contractual relationship with the child support recovery unit.

b. The child support recovery unit attorney shall issue written disclosure of the attorney-client relationship between the attorney and the state of Iowa to recipients of child support enforcement services and to all parties in a review and adjustment proceeding.

95.15(3) *Communication concerning case circumstances.*

a. The child support recovery unit shall provide case status information upon written request by any recipient of child support enforcement services or any party under the review and adjustment procedure, unless otherwise prohibited by state or federal statute or rules pertaining to confidentiality.

b. All communications with other parties will be directed to those parties personally, unless a licensed attorney has entered an appearance or notified the child support recovery unit in writing that the attorney is representing a party. If any party is represented by counsel, all communications shall be directed to counsel for that party.

c. When a party is receiving public assistance, the unit shall refer any suspected fraud or questionable family investment program expenditures to the appropriate governmental agencies.

This rule is intended to implement Iowa Code sections 252B.5 to 252B.7 and 598.21.

441—95.16(252B) Handling and use of federal 1099 information. Data from the collection and reporting system is matched with federal 1099 records for information on assets and income. Verified 1099 information may be used for: establishing support orders, modifying support orders under the review and adjustment process and enforcing payment of support debts.

95.16(1) *Security of 1099 information.* Information received from the federal source, 1099, shall be safeguarded in accordance with Internal Revenue Code Section 6103(p)(4). Information shall be kept in a secure section of the state computer system and not released until verified by a third party.

95.16(2) *Verification of 1099 information.* Prior to release of any information to the local child support recovery office, the information shall be verified by a third party as follows:

a. When information indicates there may be assets available from a financial institution, the child support recovery unit shall secure verification of these assets from the financial institution on Form 470-3170, Asset Verification Form.

b. When address information is received, the child support recovery unit shall secure verification of the address information from the post office on Form 470-0176, Address Information Request.

c. When employment information is received, the child support recovery unit shall secure verification of the employment from the employer on Form 470-0177, Employer Information Request.

This rule is intended to implement Iowa Code section 252B.9.

441—95.17(252B) Effective date of support. For all original orders established by the child support recovery unit, the effective date of the support obligation under the orders shall be the twentieth day following the date the order is prepared by the unit, unless otherwise specified.

441—95.18(252B) Continued services available to canceled family investment program (FIP) or Medicaid recipients. Support services shall automatically be provided to persons who were eligible to receive support services as recipients of FIP or Medicaid and who were canceled from FIP or Medicaid. Continued support services shall not be provided to a person who has been canceled from FIP or Medicaid when a claim of good cause, as defined at 441—subrule 41.22(8) or 441—subrule 75.14(3), as appropriate, was valid at the time assistance was canceled or when one of the reasons for termination of services, listed at rule 441—95.14(252B), applies to the case.

Support services shall be provided to eligible persons without application or application fee, but subject to applicable enforcement fees.

95.18(1) *Notice of services.* When a family is no longer eligible for public assistance, the department shall forward Form 470-1981, Notice of Continued Support Services, to the family's last-known address within five working days of the notification of ineligibility, to inform the family:

a. That, unless the family notifies the department to the contrary, services will continue.

b. Of the effect of continuing to receive support services, including the available services and the state's policies on fees, cost recovery, and distribution.

95.18(2) *Termination of services.* A person may request the department to terminate support services at any time by the completion and return of the appropriate portion of Form 470-1981, Notice of Continued Support Services, or in any other form of written communication, to the child support recovery unit.

Continued support services may be terminated at any time for any of the reasons listed in rule 441—95.14(252B).

95.18(3) *Reapplication for services.* A person whose services were denied or terminated may reapply for services under this chapter by completing the application process and paying the application fee described in subrule 95.2(4).

This rule is intended to implement Iowa Code section 252B.4.

441—95.19(252B) Cooperation of public assistance recipients in establishing and obtaining support. If a person who is a recipient of FIP or Medicaid is required to cooperate with the child support recovery unit in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the following shall apply:

95.19(1) *Cooperation defined.* The person shall cooperate in good faith in obtaining support for persons whose needs are included in the assistance grant or Medicaid household, except when good cause or other exception as defined in 441—subrule 41.22(8) or 75.14(8) for refusal to cooperate, is established.

a. The person shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom assistance or Medicaid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom assistance or Medicaid is claimed.

(3) Obtaining support payments for the person and the child for whom assistance is claimed, and obtaining medical support for the person and child for whom Medicaid is claimed.

b. Cooperation is defined as including the following actions by the person if the action is requested by the child support recovery unit:

(1) Providing the name of the noncustodial parent and additional necessary information.

(2) Appearing at the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the person that is relevant to achieving the objectives of the child support recovery program.

(3) Appearing at judicial or other hearings, proceedings or interviews.

(4) Providing information or attesting to the lack of information, under penalty of perjury.

(5) If the paternity of the child has not been legally established, submitting to blood or genetic tests pursuant to a judicial or administrative order. The person may be requested to sign a voluntary affidavit of paternity after being given notice of the rights and consequences of signing such an affidavit as required by the statute in Iowa Code section 252A.3A. However, the person shall not be required to sign an affidavit or otherwise relinquish the right to blood or genetic tests.

c. The person shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the noncustodial parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity or to secure medical support. This includes completing and signing Form 470-3877, Child Support Information, if requested, as well as documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

95.19(2) *Failure to cooperate.* The local child support recovery unit shall make the determination of whether or not a person has cooperated with the unit. The child support recovery unit shall promptly send notice of a determination of noncooperation to the person on Form 470-3400, Notice of Noncooperation, and notify the FIP and Medicaid programs, as appropriate, of the noncooperation determination and the reason for the determination. The FIP and Medicaid programs shall take appropriate sanctioning actions as provided in statute and rules.

95.19(3) *Good cause or other exception.*

a. A person who is a recipient of FIP assistance may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—subrules 41.22(8) through 41.22(12).

b. A person who is a recipient of Medicaid may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—subrule 75.14(3).

This rule is intended to implement Iowa Code section 252B.3.

441—95.20(252B) Cooperation of public assistance applicants in establishing and obtaining support. If a person who is an applicant of FIP or Medicaid is required to cooperate in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the requirements in 441—subrule 41.22(6) and rule 441—75.14(249A) shall apply. The appropriate staff in the FIP and Medicaid programs are designees of the child support recovery unit to determine noncooperation and issue notices of that determination until the referral to the unit is completed.

This rule is intended to implement Iowa Code section 252B.3.

441—95.21(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases.

95.21(1) *Requirements.* The individual receiving nonpublic assistance support services shall cooperate with the child support recovery unit by meeting all the requirements of rule 441—95.19(252B), except that the individual may not claim good cause or other exception for not cooperating.

95.21(2) *Failure to cooperate.* The child support recovery unit shall make the determination of whether or not the nonpublic assistance applicant or recipient of services has cooperated. Noncooperation shall result in termination of support services. An applicant or recipient may also request termination of services under 95.14(1)*"b"*(1).

This rule is intended to implement Iowa Code section 252B.4.

441—95.22(252B) Charging pass-through fees. Pass-through fees are fees or costs incurred by the department for service of process, genetic testing and court costs if the entity providing the service charges a fee for the services. The child support recovery unit may charge pass-through fees to persons who receive continued services according to rule 441—95.18(252B) and to other persons receiving nonassistance services, except no fees may be charged an obligee residing in a foreign country or the foreign country if the unit is providing services under paragraph 95.2(2)*"b."*

This rule is intended to implement Iowa Code section 252B.4.

441—95.23(252B) Reimbursing assistance with collections of assigned support. For an obligee and child who currently receive assistance under the family investment program, the full amount of any assigned support collection that the department receives shall be distributed according to rule 441—95.3(252B) and retained by the department to reimburse the family investment program assistance.

This rule is intended to implement Iowa Code section 252B.15.

441—95.24(252B) Child support account. The child support recovery unit shall maintain a child support account for each client. The account, representing money due the department, shall cover all periods of time public assistance has been paid, commencing with the date of the assignment. The child support recovery unit will not maintain an interest-bearing account.

This rule is intended to implement Iowa Code chapter 252C.

441—95.25(252B) Emancipation verification. The child support recovery unit (CSRU) may verify whether a child will emancipate according to the provisions established in the court order prior to the child's eighteenth birthday.

95.25(1) *Verification process.* CSRU shall send Form 470-2562, Emancipation Verification, to the obligor and obligee on a case if CSRU has an address.

95.25(2) *Return information.* The obligor and obligee shall be asked to complete and return the form to the unit. CSRU shall use the information provided by the obligor or obligee to determine if the status of the child indicates that any previously ordered adjustments related to the obligation and a child's emancipation are necessary on the case.

95.25(3) *Failure to return information.* If the obligor and obligee fail to return the questionnaire, CSRU shall apply the earliest emancipation date established in the support order to the case and implement changes in support amounts required in the support order.

95.25(4) *Conflicting information returned.* If conflicting information is returned or made known to CSRU, CSRU shall have the right to verify the child's status through sources other than the obligor and obligee.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4.

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CHAPTER 96
INFORMATION AND RECORDS

PREAMBLE

Title IV-D of the Social Security Act provides that state child support agencies providing services under the Act shall have access to information and records from third parties to assist in providing services. Information and records shall be provided as specified in these rules, other rules, Iowa statutes, and federal statute and regulations. These rules implement a procedure for the child support agency to request or administratively subpoena information from employers and other sources, and provide an appeal procedure before imposition of the statutory fine for failure to comply.

441—96.1(252B) Access to information and records from other sources. In addition to statutes and other rules, the following entities shall provide information and records based on the following methods of requesting the information and within the following time frame:

96.1(1) *Oral or written request.* All persons and entities, including all for-profit, nonprofit, and governmental employers, shall, within 15 days of receipt of a request, provide the child support recovery unit or a child support agency of another state information on the employment, compensation, and benefits of any individual employed by the person or entity as an employee or contractor if the unit or agency is providing services in relation to that individual. The request may be made orally, by letter, by form or by other written request listed in subrule 96.1(3); however, the fine and procedures described in rules 96.2(252B) to 96.6(252B) only apply if the request was by a written request listed in subrule 96.1(3).

96.1(2) *Subpoena.* All persons and entities shall comply with a Child Support Recovery Unit Subpoena, Form 470-3413, issued by the child support recovery unit, or an Administrative Subpoena, OMB Control # 0970-0152, or its successor, issued by the unit or a child support agency of another state, as provided in Iowa Code section 252B.9. The child support recovery unit or a child support agency of another state may issue a subpoena regarding more than one individual. The person or entity shall provide the information and records as directed in Form 470-3413 or the Administrative Subpoena.

96.1(3) *Time to reply to a written request.* A person or entity who is sent any of the following shall provide the information and records requested in the manner requested to the child support recovery unit or child support agency of another state, as appropriate, within 15 days of the date of the request.

a. Form 470-3232, Employer Verification Request, Form 470-0177, Employment and Health Insurance Questionnaire, or other forms as specified in appropriate rules from the child support recovery unit which request information described at subrule 96.1(1).

b. Form 470-3413, Child Support Recovery Unit Subpoena, or an Administrative Subpoena, OMB Control # 0970-0152, or its successor, as provided at subrule 96.1(2), from the child support recovery unit.

c. A written request or form as provided at subrule 96.1(1) from a child support agency of another state.

d. An Administrative Subpoena, OMB Control # 0970-0152, or its successor, as provided at subrule 96.1(2), from a child support agency of another state.

441—96.2(252B) Refusal to comply with written request or subpoena.

96.2(1) A parent or putative father in a support or paternity proceeding in which the child support recovery unit or a child support agency of another state is providing services who fails to comply with a request or subpoena as provided in subrule 96.1(3) shall be subject to license sanctioning as provided in 441—Chapter 98, Division VIII.

96.2(2) An entity or a person who is not a parent or putative father as described in subrule 96.2(1) may refuse to comply under the circumstances provided in rule 441—96.3(252B).

441—96.3(252B) Procedure for refusal.

96.3(1) *No information.* A person or entity who does not have any information or records requested or subpoenaed shall respond as follows:

a. If the request or subpoena is a form from the child support recovery unit under paragraph 96.1(3)*"a"* or *"b,"* the person or entity shall sign and return to the unit the appropriate portion of the form indicating the lack of information or records.

b. If the request or subpoena is one listed in paragraphs 96.1(3)*"c"* or *"d,"* the person or entity shall send the child support agency of the other state a signed and dated written statement indicating the lack of information or records.

96.3(2) *Good cause.* The person or entity may claim good cause for refusing to comply as required in Iowa Code section 252B.9.

a. To claim good cause, the person or entity shall file a request for a conference by mailing or submitting a written request to the child support recovery unit which issued the request or subpoena within 15 days of the issuance of the request or subpoena.

b. If a child support agency of another state issued the request or subpoena, the person or entity may request a conference with the child support recovery unit or with the child support agency of the other state. The person or entity shall request a conference with the child support recovery unit by mailing or submitting a written request and a copy of the subpoena or document received from the child support agency of the other state to the Iowa Department of Human Services, Bureau of Collections, Central Registry, P.O. Box 9218, Des Moines, Iowa 50306-9218. The person or entity shall request a conference with the child support agency of the other state by following the requirements of that state's laws and regulations.

441—96.4(252B) Conference conducted.

96.4(1) *Request or subpoena issued by CSRU.* If the child support recovery unit issued the request or subpoena, the unit shall notify the person or entity and conduct a conference within ten days of receipt of the request for a conference. At the request of either the unit or the person or entity, the conference may be rescheduled one time. The conference may be conducted in person or by telephone.

96.4(2) *Request or subpoena issued by other state.* If a conference with the child support recovery unit is requested based upon a request or subpoena issued by a child support agency of another state, the bureau chief, as defined at rule 441—95.1(252B), shall request that agency send an interstate referral and appropriate information to the unit or central registry.

a. The child support recovery unit shall notify the person or entity and conduct a conference within ten days of opening a case based upon an interstate referral and appropriate information. If the child support recovery unit does not receive an interstate referral and appropriate information within 60 days of the bureau chief's request, the request or subpoena received under subrule 96.1(3) shall be void, and the child support recovery unit shall notify the person or entity it is void.

b. The voiding of a request or subpoena under this subrule shall not prevent the issuance of subsequent requests or subpoenas.

96.4(3) *Submission of information.* On or before the conference date, the person or entity shall submit information to the child support recovery unit which demonstrates a mistake in the identity of the person or entity, or a mistake in the identity of the individual who is the subject of the request or subpoena, or which demonstrates a specific prohibition under federal law to release of the information or records. The child support recovery unit may extend the time to conduct the conference an additional ten days to allow time for the person or entity to provide the information.

96.4(4) *Notice of findings.* Following the conference, the unit shall issue a notice as provided in Iowa Code section 252B.9.

441—96.5(252B) Fine assessed.

96.5(1) *Conditions resulting in fine.* The child support recovery unit shall assess a fine of $100 per refusal and notify the person or entity of the fine if any one of the following applies:

a. Ten days have passed since the unit issued a notice under subrule 96.4(4) stating the unit determined there is no good cause to refuse to comply with the request or subpoena, and the information or records have not been received.

b. Fifteen days have passed since the child support recovery unit issued the request or subpoena and the information or records have not been received, nor has the person or entity filed a request for a conference.

c. Fifteen days have passed since a child support agency of another state has issued the request or subpoena, and that agency sends an interstate referral to the child support recovery unit requesting enforcement of the request or subpoena because the information or records were not received.

96.5(2) *Definition of refusal.* One refusal is a refusal to supply information or records based on one written request, or one subpoena regarding one or more individuals.

96.5(3) *Notification of fine.* If the child support recovery unit assesses a fine, the unit shall notify the person or entity by regular mail with proof of service completed according to Rule of Civil Procedure 1.442. The person or entity shall have 30 days from the date of the notice to pay the fine.

441—96.6(252B) Objection to fine or failure to pay.

96.6(1) *Objection filed.* The person or entity may object to the imposition of the fine by filing an application for judicial review in district court within 30 days of issuance of the notice of the fine, and sending a copy of the application to the child support recovery unit.

96.6(2) *Petition to compel.* If the person or entity fails to pay the fine imposed, and does not file an application for judicial review within the time provided in this rule, the child support recovery unit may file a petition to compel the person or entity to comply with the request, subpoena or fine in district court in the county in which the underlying support order or pending matter is filed. If there is no support order or pending matter filed in district court in Iowa, then the unit may file the petition in the county in which the person resides, or the person or entity has its principal place of business.

96.6(3) *Certification to court.* If the person, entity, or the child support recovery unit files an action in district court, the unit shall certify a copy of the following, as appropriate, to the court prior to a hearing:

a. Proof of service of the request or subpoena.

b. Proof of service of the notice of assessment of a fine.

c. Written decision following a conference.

96.6(4) *Failure to comply with court order.* Failure of the person or entity to comply with an order of the district court shall be subject to enforcement through contempt of court.

These rules are intended to implement Iowa Code section 252B.9.

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CHAPTER 97
COLLECTION SERVICES CENTER

PREAMBLE

The collection services center is the public agency designated by state law as the state disbursement unit with responsibility for the receipt, recording and disbursement of specified support payments within the state of Iowa. The administrative guidelines within this chapter describe the process of transferring support cases or information from the clerks of district court to the collection services center and the policies and procedures used to receive, monitor, and distribute support payments.

441—97.1(252B) Definitions. The definitions of terms used in this chapter shall follow those terms defined in rule 441—95.1(252B) with the exception or addition of the following:

"Collection services center" means the public agency designated to receive, record, monitor, and disburse support payments as defined in Iowa Code section 598.1, 252B.15 or 252D.16, in accordance with Iowa Code sections 252B.13A and 252B.14.

"Correlated non-IV-D case" means a non-IV-D case where income withholding information must be maintained by the unit in order to properly process an income withholding payment because the obligor has both a non-IV-D and a current or former IV-D case.

"Electronic funds transmission" means, for purposes of this chapter, the use of a NACHA-approved child support format for the electronic transmission of funds to the collection services center.

"Employee" shall have the same meaning provided this term in Iowa Code section 252G.1.

"Former IV-D case" means a case that previously received services from the unit under rule 441—95.2(252B) but currently receives only payment processing services from the collection services center.

"Insufficient funds payment" means a support payment by check or other financial instrument which is dishonored, not paid, or the funding of the payment is determined to be inadequate.

"IV-D case" means a case that receives services from the unit under rule 441—95.2(252B), including payment processing services from the collection services center.

"NACHA-approved child support format" means a child support payment transmission format approved by the National Automated Clearing House Association (NACHA).

"Non-IV-D case" means a support order that never received services from the unit under rule 441—95.2(252B), but that receives payment processing services from the collection services center for income withholding payments.

"Obligee" means the guardian, custodial parent, person, or entity entitled to receive support payments.

"Obligor" means a parent, relative, or any other person declared to be legally liable for the support of a child or the custodial parent or guardian of the child.

"Payor of income" shall have the same meaning provided this term in Iowa Code section 252D.16.

"Support payment" shall have the same meaning provided this term in Iowa Code section 252D.16.

"Unit" means the child support recovery unit as defined in Iowa Code section 252B.2.

"Web site" means the Web site operated by the department of human services for the purpose of allowing a payor of income to make a support payment through electronic transmission to the collection services center.

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441—97.2(252B) Transfer of records and payments. For non-IV-D cases, the clerk of court shall provide core case information to the unit upon the filing of a new income withholding order or upon the request of the unit. "Core case information" means information listed in paragraphs 97.2(1)*"a"* and *"b"* and subrule 97.2(2). For IV-D and correlated non-IV-D cases, the clerk of court shall provide detailed case information to the unit upon request. After the establishment of a case, the unit shall send notices of transfer to obligors, obligees, and payors of income based upon case type.

97.2(1) *Transfer of information on non-IV-D and correlated non-IV-D cases.*

a. In non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

(1) The obligor's name and address.

(2) The obligee's name and address.

(3) The court order numbers.

b. In correlated non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

(1) The obligor's name and address.

(2) The obligee's name and address.

(3) The court order numbers.

(4) The income withholding order.

c. The clerk of the district court shall provide case information to the unit on a regular basis when an income withholding order is filed with a clerk of court or when the unit requests the information in order to process a payment.

d. The unit shall automatically create cases for payment processing based upon the information received from the clerks of court.

97.2(2) *Transfer of information on IV-D cases.* In IV-D cases, the clerk of district court shall provide the unit with the following information if the information has been provided to the clerk upon request of the unit:

a. The obligee's name, date of birth, last-known mailing address, the social security number if known and, if different in whole or part, the names of the persons to whom the obligation of support is owed by the obligor.

b. The name, birth date, social security number, and last-known mailing address of the obligor.

c. A copy of all support orders that establish or modify a support amount.

d. The names, social security numbers, and dates of birth of any minor dependents for whom support is ordered, if available.

e. A record of any support payments received by the clerk of district court prior to the transfer of case information and any payments received by the collection services center and the date of transfer to the collection services center.

f. A record of any determination of controlling order under the Uniform Interstate Family Support Act.

441—97.3(252B) Support payment records. Each IV-D, former IV-D and non-IV-D case type shall have an official payment record.

97.3(1) *Official records for cases.* The official payment records for each case type shall be maintained by a designated entity.

a. The collection services center shall establish, maintain and certify the official support payment records for IV-D or former IV-D cases.

b. The clerk of the district court shall establish, maintain and certify the official support payment records for non-IV-D and correlated non-IV-D cases. The collection services center shall establish and maintain records for receipt and disbursement of income withholding payments for these cases, but shall not certify these records as the complete payment record.

97.3(2) *Informal conference for payment records.* The unit shall provide an informal conference or desk review regarding the contents of any support payment record to the obligor or obligee upon request.

a. In IV-D or former IV-D cases, the conference shall be available to review the payment record and to answer questions of the obligee or obligor regarding the accuracy of the record.

b. In non-IV-D and correlated non-IV-D cases, the conference shall be available to review the accuracy of the contents of any record of income withholding payments.

97.3(3) *Certified payment records.* The unit shall provide certified copies of the official support payment records as defined in paragraph 97.3(1)*"a"* in accordance with Iowa Code section 252B.9.

[**ARC 1262C**, IAB 1/8/14, effective 3/1/14]

441—97.4(252B) Method of payment. Payments shall be accepted in specific forms from obligors and payors of income.

97.4(1) *Form of payment.* Except as otherwise provided in this rule and in rule 441—97.5(252D), support payments may be paid in the form of cash, check, bank draft, money order, preauthorized withdrawal of funds, or other financial instrument, and sent by mail to the collection services center, or by electronic transmission of funds.

97.4(2) *Treatment of insufficient funds payments.* The unit shall have a process in place to handle insufficient funds payments.

a. An obligor submitting an insufficient funds support payment to the collection services center shall be required to submit payments by cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

b. A payor of income submitting an insufficient funds support payment to the collection services center shall be required to submit payments through electronic funds transmission, cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

c. Insufficient funds payments shall not be credited to the collection services center account for the obligor or shall be removed from the account if credited before sufficiency was verified. Insufficient funds support payments shall be subject to additional collection by the collection services center for the dishonored amount.

d. The collection services center shall not process additional payments other than cash, bank drafts or money orders from an obligor or payor of income who has previously submitted insufficient funds payments without first verifying the payment. The collection services center shall have a process in place to allow the obligor or the payor of income the opportunity to replace any additional moneys submitted for payment of support before processing in order to avoid additional insufficient funds entries into the official payment records on the affected cases.

97.4(3) *Distribution of payment.* Nonincome withholding support payments received by the collection services center in IV-D, former IV-D, non-IV-D, or correlated non-IV-D cases which are not directed to a specific account or support obligation shall first be applied proportionately to the current support obligation on all cases for the obligor and, secondly, to the support arrearages owed by the obligor.

[**ARC 9351B**, IAB 2/9/11, effective 4/1/11]

441—97.5(252D) Electronic transmission of payments. Payors of income shall electronically transmit to the collection services center the amounts withheld under an income withholding order.

97.5(1) *Thresholds for electronic funds transmission.* A payor of income shall transmit payment through electronic funds transmission if either of the following applies:

a. The payor of income employs 100 or more employees and uses an agent for payroll processing.

b. The payor of income employs 200 or more employees.

97.5(2) *Use of the Web site.* Unless paragraph 97.4(2)*"b"* applies, a payor of income required to use electronic funds transmission under subrule 97.5(1) may elect to submit payments electronically by using the Web site if the payor of income determines that using electronic funds transmission would cause undue hardship.

97.5(3) *Implementing electronic funds transmission.* A payor of income implementing electronic funds transmission shall complete all the following before the implementation date specified in subrule 97.5(5):

a. Contact the collection services center to obtain file layout and case reconciliation information.

b. Provide to the collection services center:

(1) The contact information for the person responsible for electronic funds transmission for the payor of income or the payor of income's agent for payroll processing;

(2) The contact information for the person responsible for payroll accounts for the payor of income or the payor of income's agent for payroll processing;

(3) The name and address of the authorized financial institution from which the payment will be withheld; and

(4) A sample file layout in a NACHA-approved child support format and, if necessary, a test file in a NACHA-approved child support format.

c. If needed upon review by the collection services center:

(1) Make corrections to the file layout to meet a NACHA-approved child support format, and

(2) Provide a corrected copy to the collection services center for review.

d. Upon approval of the file layout by the collection services center, provide an implementation date before the first submission of payment through electronic funds transmission.

97.5(4) *Maintaining information and file format after implementation.* A payor of income that has implemented electronic funds transmission shall:

a. Transmit both payment amounts and detailed information records in accordance with a NACHA-approved child support format.

b. Advise the collection services center of a payment error within two business days.

c. Provide the collection services center ten working days' advance notice when changing between NACHA-approved child support formats.

d. Correct case number or file problems identified by the collection services center before sending any additional files.

97.5(5) *Time frames for implementation.* A payor of income shall comply with the following implementation schedule:

a. A payor of income that employs 1,000 or more employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2011.

b. A payor of income that employs between 500 and 999 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2012.

c. A payor of income that employs between 200 and 499 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.

d. A payor of income that employs 100 or more employees and uses an agent for payroll processing shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.

97.5(6) *Exemption from electronic transmission.* To avoid undue hardship, a payor of income that has fewer than 200 employees or a payor of income that has fewer than 100 employees and uses an agent for payroll processing is exempt from using electronic transmission unless subrule 97.4(2) applies.

[**ARC 9351B**, IAB 2/9/11, effective 4/1/11]

441—97.6(252B) Authorization of payment. The collection services center must authorize the generation of payments for support paid. The collection services center shall issue payments as follows:

97.6(1) *Submittal of information to department of administrative services.* In order to disburse payments to the obligee within two working days, the collection services center shall submit information daily to the department of administrative services to issue a warrant or electronic file transfer (EFT) payment to the obligee.

97.6(2) *Release of funds.* The following workday an electronic transfer of funds shall be sent to the designated account of the obligee or an alternate account to be accessed by the obligee through an electronic access card, or if subrule 97.6(5) applies, a state warrant may be sent by regular mail to the last-known address of the obligee.

97.6(3) *Electronic transfer.* Obligees who want electronic transfer of support payments to a designated account shall complete Form 470-2612, Authorization for Automatic Deposit, and submit it to the collection services center. Unless subrule 97.6(5) applies, any obligee not using automatic deposit to a designated account shall be issued an electronic access card for receipt of support payments.

97.6(4) *Walk-ins.* Support payments shall not be hand-delivered to the obligee on a walk-in basis.

97.6(5) *Warrants.* The collection services center may authorize generation of a warrant if any one of the following conditions applies:

a. Generation of a warrant is necessary to meet federal requirements to disburse a payment to an obligee within two working days when electronic transfer is not feasible.

b. The obligee has not requested automatic deposit to a designated account of the obligee, and payment is from a source that is nonrecurring or is not expected to continue in a 12-month period.

c. The obligee has not requested automatic deposit to a designated account of the obligee and has asserted in writing on Form 470-3972, Electronic Support Payments, that one of the exemptions listed in this paragraph applies. To claim an exemption, the obligee must return Form 470-3972 to the collection services center within ten days of the date the form was issued. An exemption granted under this paragraph is subject to periodic review by the collection services center. When the collection services center reviews an exemption, it shall issue Form 470-3973, Review of Electronic Transfer Exemption, to the obligee for completion. The exemptions available under this paragraph are:

(1) A physical disability imposes a hardship in accessing an electronically transferred payment.

(2) A mental disability imposes a hardship in accessing an electronically transferred payment.

(3) A language barrier imposes a hardship in accessing an electronically transferred payment.

(4) A literacy barrier imposes a hardship in accessing an electronically transferred payment.

(5) The obligee's home and work addresses are more than 30 miles from an automated teller machine and more than 30 miles from a financial institution where the account funds can be accessed.

d. The representative payee, court appointee, or trustee notifies the collection services center or unit in writing that one of the following applies:

(1) The obligee is under a court-ordered guardianship or conservatorship.

(2) The obligee is involved in other legal proceedings, including bankruptcy, which require payments to be sent to a trustee or other representative payee.

441—97.7(252B) Processing misdirected payments. If the collection services center receives a payment for which a corresponding obligee cannot be identified, the collection services center shall contact the person or entity that directed the payment to obtain additional information. Payments inappropriately directed to the collection services center shall be returned to the person or entity sending the payment.

These rules are intended to implement Iowa Code sections 252B.13A through 252B.17 and section 252D.17.

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CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

PREAMBLE

In addition to the enforcement services described in 441—Chapter 95, "Collections," the child support recovery unit is charged with the responsibility to provide the services delineated in this chapter.

DIVISION I
MEDICAL SUPPORT ENFORCEMENT

441—98.1(252E) Definitions.

"Medical support" means either the provision of a health benefit plan, including a group or employment-related or an individual health benefit plan, or a health benefit plan provided pursuant to Iowa Code chapter 514E to meet the medical needs of a dependent and the cost of any premium required by a health benefit plan, or the payment to the obligee of a monetary amount in lieu of a health benefit plan, either of which is an obligation separate from any monetary amount of child support ordered to be paid. Medical support is not alimony.

"Obligee" means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

"Obligor" means a noncustodial parent or other natural person legally responsible for the support of a dependent.

"Reasonable in cost" means that a health insurance is employment-related or other group health insurance regardless of the service delivery mechanism.

441—98.2(252E) Provision of services. The child support recovery unit shall provide medical support enforcement services to recipients of Medicaid for whom an assignment of support is in effect and shall provide these services to nonpublic assistance recipients upon their request.

98.2(1) *Nonpublic assistance recipients.*

a. Applicants for nonpublic assistance services shall be informed of the availability of medical support enforcement services at the time of application and shall be asked about their desire to receive these services on Form CS-3103-0, Application for Non-Assistance Support Enforcement Service. Applicants who do not desire medical support enforcement services at the time of application may request these services in writing at a later date by completing Form 470-2744, Nonpublic Assistance Medical Support Request.

b. The child support recovery unit shall inform recipients of nonpublic assistance services whose application forms did not contain notice of medical support enforcement services of the availability of these services in writing on Form 470-2744 prior to establishing or enforcing medical support, and shall not provide these services unless a written request is received.

98.2(2) *Public assistance recipients.* Unless good cause has been established, recipients of Medicaid are required to cooperate with the child support recovery unit as a condition of eligibility as prescribed in rule 441—75.14(249A). This includes completing and signing Form 470-2748, Public Assistance Medical Support Request, upon request of the child support recovery unit.

441—98.3(252E) Establishing medical support. Nullified; see note at end of chapter.

441—98.4(252E) Accessibility of the health benefit plan. When a choice of employment-related or group health benefit plans is offered to the obligor, some of which are of little or no value to the dependents because the dependents reside outside the geographic area served by the health benefit plans, the child support recovery unit shall request through a petition or notice of support debt that the obligor provide a plan that is accessible to the dependents.

441—98.5(252E) Health benefit plan information. The unit shall gather information concerning a health benefit plan.

98.5(1) *Information from an employer.* The unit shall gather information concerning a health benefit plan an employer may offer an obligor as follows:

a. The unit shall send Form 470-0177, Employment and Health Insurance Questionnaire, or Form 470-2240, Employer Health Insurance Questionnaire, whenever a potential employer is identified.

b. The unit shall secure medical support information from a known employer on Form 470-2743, Employer Medical Support Information, when Form 470-3818, Medical Support Notice, or an order has been forwarded to the employer pursuant to Iowa Code section 252E.4.

98.5(2) *Information from an obligor.* The unit may secure medical support information from an obligor on Form 470-0413, Obligor Insurance Questionnaire.

98.5(3) *Disposition of information.* The unit shall provide the information:

a. To the Medicaid agency and to the obligee when the dependent is a recipient of Medicaid.

b. To the obligee when the dependent is not a recipient of Medicaid.

441—98.6(252E) Insurer authorization. When the obligor does not provide to the insurer the signed documents necessary to enroll and process claims for the dependent for whom support is ordered, the insurer is authorized to accept the signature of the obligee or the department's designee on necessary forms. For purposes of Division I of this chapter, the third-party liability unit is the department's designee when support is assigned.

441—98.7(252E) Enforcement.

98.7(1) *Medical support enforcement.* For the purposes of enforcement, medical support may be reduced to a dollar amount and collected through the same remedies available for the collection and enforcement of child support.

98.7(2) *Health benefit plan or insurance.*

a. If an obligor was ordered to provide a health benefit plan or insurance coverage under an order, but did not comply with the order, the child support recovery unit may implement the order by forwarding to the employer a copy of the order, an ex parte order as provided in Iowa Code section 252E.4, or Form 470-3818, Medical Support Notice.

b. If the child support recovery unit implements an order under this subrule, the unit shall send a notice to the obligor at the last-known address of the obligor by regular mail. The notice shall contain the following information:

(1) A statement of the obligor's right to an informal conference.

(2) The process to request an informal conference.

(3) The obligor's right to file a motion to quash with the district court.

98.7(3) *Termination of employment.* When the child support recovery unit receives information indicating the obligor's employment has terminated, the unit shall secure the status of the health benefit plan by sending Form 470-3218, Employer Insurance Notification, to the employer.

If no response is received within 30 days of sending Form 470-3218, the unit shall send a second request on Form 470-3219, Employer Insurance Second Notification, to the employer. If the obligor does not notify the unit, or no response is received from the employer within 90 days of sending Form 470-3218, the unit shall notify the obligee that the health benefit plan may have terminated.

441—98.8(252E) Contesting the order. The obligor may contest the enforcement of medical support by means of an informal conference with the child support recovery unit, or by filing a motion to quash.

98.8(1) *Motion to quash.* Procedures for filing a motion to quash the order are specified under Iowa Code sections 252D.31 and 252E.6A.

98.8(2) *Informal conference.*

a. The obligor shall be entitled to only one informal conference for each new employer to which the unit has forwarded Form 470-3818, Medical Support Notice, or order under Iowa Code section 252E.4 to enforce medical support.

b. Procedures for the informal conference are as follows:

(1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the enforcement was entered in error.

(3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time if a mistake of fact regarding the identity of the obligor is believed to have been made.

(4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) The child support recovery unit may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

(7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.

c. The issues to be reviewed at the conference shall be as follows:

(1) Whether the identity of the obligor is in error.

(2) Whether the obligor is already providing health benefit plan coverage for the dependent.

(3) Whether the availability of dependent coverage under a health benefit plan is in error.

(4) Whether the obligor was ordered to provide a health benefit plan coverage under the support order.

d. The results in an informal conference shall in no way affect the right of the obligor to file a motion to quash the order under Iowa Code section 252E.4.

These rules are intended to implement Iowa Code sections 252A.4, 252B.5, 252C.1, 252C.3, 252C.4, 252C.9, 252D.1, 252D.30, 598.1, 598.21, 598.22 and 600B.25 and Iowa Code chapter 252E.

441—98.9 to **98.20** Reserved.

DIVISION II
INCOME WITHHOLDING
PART A
DELINQUENT SUPPORT PAYMENTS

441—98.21(252D) When applicable. When there is a delinquency in an amount equal to the support payable for one month as specified by an order for support or reimbursement order and the child support recovery unit is providing services under 441—Chapter 95, the unit shall enter an order to withhold the obligor's income not exempt by state or federal law to require the income withheld to be paid to the collection services center to pay the support obligation. An income withholding order shall also be entered to collect the unpaid balance of a judgment for the reimbursement of a support debt when a repayment schedule is not specified in the order establishing the judgment.

441—98.22 and **98.23** Reserved.

441—98.24(252D) Amount of withholding. The child support recovery unit shall determine the amount to be withheld by the employer or other income providers as follows:

98.24(1) *Current support obligation exists.* When a current support obligation exists, the amount withheld shall be an amount equal to the current support obligation, and an additional amount equal to 50 percent of the current support obligation to be applied toward the liquidation of any delinquency.

Effective July 1, 1998, the amount withheld to be applied toward the liquidation of any delinquency shall be 20 percent of the current support obligation for any support order entered or modified on or after July 1, 1998, or for any support order entered or modified prior to July 1, 1998, for which no income withholding order has been filed by an Iowa CSRU prior to July 1, 1998.

a. The obligor may request a modification of the amount withheld as payment toward the arrearage or reimbursement on the grounds of hardship. The procedure for this request is described in

rule 98.43(252D). Hardship exists if the obligor's income is 200 percent or less than poverty level for one person as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

b. If hardship is claimed by the obligor, the child support recovery unit may verify income from:

(1) The employer or other income provider of the obligor.

(2) The obligor.

(3) The state employment security agency.

(4) Other records available in accordance with Iowa Code section 252B.9.

c. If the hardship criteria are met, the amount withheld as payment toward the arrears may be modified as follows:

(1) The obligor's gross yearly income shall be divided by 200 percent of the established yearly gross poverty level income for one person. That amount shall be multiplied by .5. The resulting figure will be the percent of the current support order which shall be withheld for payment on the arrearage.

(2) The amount withheld on the arrearage shall not be less than $5 per month.

(3) If criteria for withholding 20 percent toward liquidation of any delinquency are also met, the lesser of 20 percent or hardship is to be withheld.

98.24(2) *Current obligation ended.* When the current support obligation has ended or has been suspended, the income withholding order shall remain in effect until any delinquency has been satisfied. The amount withheld shall be equal to the amount of the most recent prior current support obligation which is greater than zero. Hardship criteria shall be applied in accordance with subrule 98.24(1). However, in the following circumstances, the amount withheld shall be 20 percent of the amount owed for current support at the time the obligation ended or was suspended; and, if hardship criteria are met, this amount shall be one-half of the amount established under the guidelines in subrule 98.24(1):

a. There has been a change of legal custody from the obligee to the obligor.

b. The obligee and obligor have reconciled and have obtained a modification ending the current support obligation.

c. The current obligation is suspended through the suspension process.

d. In a foster care case, the order for parental liability ended when the child left placement, or an order ending the liability has been entered and the child in foster care has returned to the home of a parent ordered to pay parental liability. In this situation, the amount withheld shall be reduced to 20 percent of the current support amount when the obligation ended, but only for the parent with whom the child resides.

98.24(3) *No support ordered.* When there is no current child support ordered and the obligation is solely the result of a judgment which does not specify a repayment schedule, the unit shall establish the amount to be withheld per month as follows:

a. Initially the amount shall be set at the amount for one person from the ADC schedule of basic needs. Hardship may be asserted as set out in subrule 98.24(1).

b. If hardship criteria are met in these circumstances, the amount withheld on reimbursement shall be determined by dividing the obligor's gross yearly income by 200 percent of the poverty level income for one person. The resulting number is the percent of the existing withholding amount that will now be withheld. This amount will be reduced by one-half if the obligor has legal custody of the child.

98.24(4) *Lump-sum income source.* Notwithstanding subrules 98.24(1), 98.24(2), and 98.24(3), when the obligor is paid by a lump-sum income source, the withholding amount may include all current and delinquent support due through the current month. Lump-sum income includes income received in a sole payment or in payments that occur at two-month or greater intervals.

98.24(5) *Disability continues.* If hardship criteria under paragraph 98.43(2)*"e"* are met and the amount withheld as payment toward the arrears is modified, the obligor is deemed to continue to meet the hardship criteria for the duration of the social security disability benefits or supplemental security income disability benefits. If those benefits have not ended, but the amount to withhold would otherwise be amended under this rule and under rule 441—98.45(252D), the unit shall determine the amount to withhold for payment toward arrears under this rule by using the same percent as was used when the

hardship amount was first determined under paragraph 98.43(2)*"e,"* but the amount shall not be less than $5 per month.

441—98.25 to **98.30** Reserved.

PART B
IMMEDIATE INCOME WITHHOLDING

441—98.31(252D) Effective date. In cases for which the child support recovery unit is providing enforcement services, the income of the obligor is subject to immediate withholding pursuant to Iowa Code section 252D.8 without regard to the existence of a delinquency in the payment of support.

441—98.32(252D) Withholding automatic. Immediate withholding of income is automatic without additional notice to the obligor unless:

98.32(1) *Good cause exists.* Good cause is found to exist by the court or child support recovery unit. For purposes of this rule, "good cause" is defined as the posting of a secured bond by the obligor sufficient to pay all current and future child support obligations, including any arrearages which may accrue.

98.32(2) *Written agreement exists.* A written agreement is reached between both parties which provides for an alternative arrangement for payment of child support subject to the following conditions:

a. Unless approved by the child support recovery unit, written agreements between the obligee and obligor to waive immediate income withholding become void when child support is assigned to this state or to another state pursuant to a statute of that jurisdiction.

b. All payments pursuant to any written agreement shall be paid as directed in Iowa Code sections 252B.14 and 598.22.

441—98.33 Reserved.

441—98.34(252D) Approval of request for immediate income withholding. When the obligee or other party to the proceeding requests immediate withholding, the child support recovery unit shall determine whether the request shall be approved.

98.34(1) *Basis for approval.* Approval of a request for immediate income withholding by the child support recovery unit may be based on:

a. Past payment record of the obligor which demonstrates an inconsistent compliance with the support order.

b. Whether the state of Iowa is providing public assistance.

98.34(2) *Request denied.* The child support recovery unit may not approve a request for immediate income withholding on cases where no public assistance has been expended and there is a prior written agreement between the obligee and obligor which has been approved by court order.

441—98.35(252D) Modification or termination of withholding. The court or the child support recovery unit may modify or revoke the income withholding based on the criteria of Iowa Code chapter 252D. However, the income withholding may not be revoked or terminated if there is any current support owed.

441—98.36(252D) Immediate income withholding amounts. The amount withheld shall be the amount of the current support obligation as specified in the support order. If a judgment for accrued support is established in the support order, the amount withheld shall be the amount due for current support and the periodic payment amount due for the accrued support as specified in the order. If no periodic payment for the accrued support is established in the support order, the amount withheld shall be the amount due for current support plus 10 percent of the amount of the current obligation to be applied to the accrued support.

441—98.37(252D) Immediate income withholding amounts when current support has ended. When the child support obligation has ended, the amounts to be withheld shall be in accordance with subrule 98.24(2).

These rules are intended to implement Iowa Code chapter 252D.

441—98.38 Reserved.

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

441—98.39(252D,252E) Provisions for medical support. An income withholding order or notice of income withholding may also include provisions for enforcement of medical support when medical support is included in the support order. The income withholding order or notice of income withholding may require implementation of dependent coverage under a health benefit plan pursuant to Iowa Code chapter 252E or the withholding of a dollar amount for medical support. Amounts withheld for medical support shall be determined in the same manner as amounts withheld for child support.

441—98.40(252D,252E) Maximum amounts to be withheld. An income withholding order or a notice issued by the child support recovery unit shall require that the employer or other income provider withhold no more than the maximum amounts allowed under the Federal Consumer Credit Protection Act, 15 U.S.C. Section 1673(b).

98.40(1) The amount of income subject to withholding shall be limited to 50 percent of the nonexempt disposable income of the obligor unless there is more than one support order for which the obligor is obligated and the criteria of 15 U.S.C. Section 1673(b) are met, or the obligor agrees to a greater amount within these limits.

98.40(2) Disposable income shall mean the nonexempt income of the obligor minus lawful deductions as prescribed by 42 U.S.C. Section 662(G).

441—98.41(252D) Multiple obligations. In the event that an obligor has more than one support obligation that is being enforced by the child support recovery unit, the unit may enter an income withholding order to enforce each obligation. The amount specified to be withheld on the arrearage under the income withholding order or notice shall be determined in accordance with rule 441—98.24(252D).

441—98.42(252D) Notice to employer and obligor. The child support recovery unit shall send the obligor and the employer or other income provider a notice of income withholding as follows:

98.42(1) *Notice to employer.* The unit may send notice to the employer or other income provider by regular mail or by electronic means in accordance with Iowa Code chapter 252D. If the unit is sending notice by regular mail, it shall send Form 470-3272, Order/Notice to Withhold Income for Child Support, or a notice in the standard format prescribed by 42 U.S.C. §666(b)(6)(A). If the unit is sending the notice by electronic means, it may include notice of more than one obligor's order and need only state once provisions which are applicable to all obligors, such as the information in paragraphs *"d," "f," "g,"* and *"i,"* of this subrule. The statement of provisions applicable to all obligors may be sent by regular mail or electronic means. The notice of income withholding shall contain information such as the following:

a. The obligor's name and social security number.

b. The amount of current support to withhold.

c. The amount of support to withhold for payment of delinquent support, if any.

d. The amount an income provider may deduct for costs of processing each support payment.

e. The child support case number.

f. The location to which payments are sent.

g. The maximum amount that can be withheld for payment of support as specified in rule 441—98.40(252D,252E).

h. The method to calculate net income.

i. Responsibilities of the income provider as specified in Iowa Code section 252D.17.

j. Responsibility, if any, of the income provider to enroll the obligor's dependent for coverage under a health benefit plan.

98.42(2) *Notice to obligor.* Form 470-2624, Initiation of Income Withholding, shall be sent to the last-known address of the obligor by regular mail. The notice shall contain the following information:

a. A statement of the obligor's right to an informal conference.

b. The process to request an informal conference.

c. The obligor's right to claim hardship criteria and the process for a claim.

d. The obligor's right to file a motion to quash the income withholding order or notice with the district court.

e. The information provided to the employer or other income provider, or a copy of the notice sent to the employer or other income provider.

f. The amount of any delinquency.

98.42(3) *Standard format.* As provided in Iowa Code section 252D.17 as amended by 1997 Iowa Acts, House File 612, section 61, an order or notice of an order for income withholding shall be in a standard format prescribed by the child support recovery unit. Form 470-3272, Order/Notice to Withhold Income for Child Support, is the standard format prescribed by the child support recovery unit, and the unit shall make a copy available to the state court administrator and the Iowa state bar association.

441—98.43(252D) Contesting the withholding. The obligor may contest the income withholding by means of an informal conference with the child support recovery unit or by filing a motion to quash.

98.43(1) *Motion to quash.* Procedures for filing a motion to quash the order or the notice of income withholding are specified in Iowa Code chapter 252D.

98.43(2) *Informal conference.*

a. The obligor shall be entitled to only one informal conference for each new or modified income withholding order or notice issued by the child support recovery unit that specifies a new or modified total amount to withhold.

b. Procedures for the informal conference are as follows:

(1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the withholding is in error or meets the hardship criteria defined by subrule 98.24(1).

(3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time, if a mistake of fact regarding the identity of the obligor or the amount of the delinquency is believed to have been made.

(4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) The child support recovery unit may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

(7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.

(8) If the child support recovery unit has not complied with subrule 98.24(1), it shall then adjust the income withholding amount.

c. The issues to be reviewed at the conference shall be as follows:

(1) For all income withholding orders or notices, whether:

1. The identity of the obligor is in error.

2. The amount of the current support obligation is in error.

(2) For orders or notices resulting from the existence of a delinquency, whether:

1. The amount of delinquent support is in error.

2. The hardship criteria are met.

3. For income withholding orders or notices issued after November 1, 1990, whether the guidelines described at rule 441—98.24(252D) were followed.

(3) For immediate income withholding orders or notices, whether the criteria of rules 441—98.32(252D) and 441—98.34(252D) were appropriately applied.

d. The results of an informal conference shall in no way affect the right of the obligor to file a motion to quash the income withholding order or notice with the court.

e. Notwithstanding paragraph 98.43(2)*"a"* and subparagraph 98.43(2)*"b"*(3), an obligor who has been awarded social security disability benefits or supplemental security income disability benefits under the federal Social Security Act may request an informal conference in writing at any time.

98.43(3) *Income withholding issued from another state.* The child support recovery unit shall follow procedures for a motion to quash or conduct an informal conference based on an income withholding order or notice issued in another state only if the unit is providing services under 441—Chapter 95.

441—98.44(252D) Termination of order. The child support recovery unit may, by ex parte order, terminate an income withholding order under the following conditions:

98.44(1) *Order entered in error.* The child support recovery unit shall terminate an income withholding order upon determination that the order was entered in error as follows:

a. The person named as the obligor in the income withholding order is not the person required to provide support under the support order being enforced.

b. For orders resulting from the existence of a delinquency, the required minimum delinquency did not exist at the time the income withholding order was entered.

98.44(2) *No support due.* In cases for which services are being provided by the child support recovery unit, the child support recovery unit shall terminate an income withholding order previously entered by the unit when the current support obligation has terminated and when the delinquent support obligation has been fully satisfied as applicable to all of the children covered by the income withholding order. In no case shall payment of overdue support be the sole basis for termination of withholding.

a. to *d.* Rescinded IAB 9/1/93, effective 11/1/93.

98.44(3) *Other circumstances.* The child support recovery unit may revoke an income withholding order under other circumstances provided the conditions of Iowa Code chapter 252D are met.

441—98.45(252D) Modification of income withholding. The child support recovery unit may modify a previously issued income withholding order or notice according to the guidelines established under rule 441—98.24(252D) if it is determined that:

98.45(1) *Current support obligation changed.* There has been a change in the amount of the current support obligation.

98.45(2) *Amount in error.* The amount required to be withheld under the income withholding order or notice is in error as follows:

a. The amount required to be withheld as current support is not the amount specified in the order for support being enforced.

b. The guidelines established in rule 441—98.24(252D) were not followed.

98.45(3) *Past-due support paid.* Any past-due support debt has been paid in full. The withholding order or notice shall be modified to require that only the current support obligation be withheld from the income of the obligor. Should a delinquency later accrue, the withholding order or notice may again be modified to secure an additional payment toward the delinquency. The amount of the arrears payment shall be set at 20 percent of the current support amount.

98.45(4) *Income withholding and determination of controlling orders.* An obligation amount different than what the child support recovery unit has been enforcing is established upon the determination of controlling order as allowed in Iowa Code section 252K.207. Upon the change to the new obligation amount, the amount withheld to be applied toward the liquidation of any delinquency shall be 20 percent.

98.45(5) *Income withholding and review and adjustment of orders.* The child support recovery unit has conducted a review of the obligation pursuant to 441—Chapter 99, Division IV. The unit shall modify the amount withheld to be applied toward the liquidation of any delinquency to 20 percent upon completion of the review and adjustment process.

98.45(6) *Disability ends.* The amount required to be withheld was based on the hardship criteria on or after September 1, 2006, and the child support recovery unit has verified that the obligor is no longer receiving social security disability benefits or supplemental security income disability benefits, unless the benefits have been changed to social security retirement benefits.

441—98.46(252D) Refunds of amounts improperly withheld. The child support recovery unit shall refund to the obligor any amounts improperly withheld and received by the department under an income withholding order or notice issued by the unit, subject to the following:

98.46(1) *Services provided by the department.* Only those amounts received by the department during the period enforcement services are being provided are subject to refund.

98.46(2) *Satisfaction of amount to withhold.* No refund shall be made unless amounts have been collected which fully satisfy the amount specified in the mandatory income withholding order or notice for the withholding period during which income has been generated.

98.46(3) *When issued.* Any amounts received in excess of the amounts specified in the order or notice to withhold shall be issued to the obligor within 30 days of discovery by the child support recovery unit, unless the obligor requests in writing that these amounts be credited toward the arrearage or future child support. If there is a dispute regarding whether there is an overpayment, the obligor may request an informal conference by following the procedures set out in subparagraphs 98.43(2)*"a"*(3) through (7). This procedure shall not preclude the obligor from utilizing other civil remedies.

98.46(4) *Recovery by department.* The department may recover payments from the obligee in excess of those described in subrule 98.46(2) which have been received by the department and improperly forwarded to the obligee.

441—98.47(252D) Additional information about hardship. The child support recovery unit shall make reasonable efforts within 13 months of September 1, 2006, to identify and incrementally send information to obligors who may meet the requirements for hardship in paragraph 98.43(2)*"e."*

These rules are intended to implement Iowa Code Supplement chapters 252D and 252E.

441—98.48 to **98.50** Reserved.

DIVISION III
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

441—98.51 to **98.60** Renumbered as 99.61 to 99.70, IAB 9/1/93, effective 11/1/93.

DIVISION IV
PUBLICATION OF NAMES

441—98.61(252B) List for publication. The department may compile and make available for publication a list of cases in which no payment has been credited to an accrued or accruing support obligation during a previous three-month period, subject to the following:

98.61(1) *Support order entered in Iowa.* The list shall include cases with a support order entered in Iowa which is being enforced by the child support recovery unit.

98.61(2) *Support order entered in another state.* The list may include cases with a support order entered in another state, if another state has requested this service, has demonstrated that the provision of this service is not in conflict with the laws of the state where the support order is entered, and the order is being enforced by the child support recovery unit.

98.61(3) *When compiled.* The department shall determine when to compile the list, but shall not be required to do so.

98.61(4) *Case selection.* Case selection shall be based on the records of the department at the time the list is compiled. The three-month period of nonpayment shall end no earlier than one month prior to the date the list is compiled. When an obligor has multiple orders on a case, all orders contained in the child support recovery unit record may be listed.

98.61(5) *Good cause.* The name of the obligor shall not be included when there has been a finding of good cause for noncooperation with the child support recovery unit in a public assistance case pursuant to 441—subrule 41.2(8) or 441—subrule 75.14(1) and a determination has been made that enforcement may not proceed without risk of harm to the child or caretaker.

441—98.62(252B) Releasing the list. The department may release the information, no more than twice annually, as follows:

98.62(1) *Release to media.* The department shall issue a press release to the weekly and daily newspapers in Iowa describing the manner in which a copy of the list may be obtained. Cost of producing the list shall be borne by the department. Costs of producing and transmitting a copy of the list shall be borne by the recipient of the copy.

98.62(2) *Availability of list.* Once released, the list shall be provided to other persons upon payment of an amount to cover the cost of producing a copy as specified in 441—subrule 9.3(7). Requests shall be directed to the Bureau of Collections, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114.

These rules are intended to implement Iowa Code section 252B.9.

441—98.63 to **98.70** Reserved.

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

441—98.71(252B) Seek employment order. The child support recovery unit (CSRU) may enter an ex parte order requiring the obligor to seek employment if employment of the obligor cannot be verified and if the obligor has failed to make support payments. Any obligor who has failed to make support payments and for whom employment cannot be verified is subject to issuance of an administrative order to seek employment.

441—98.72(252B) Effective date of order. The seek employment order shall be effective 15 days after issuance of the order to the obligor. This 15-day period shall serve as advance notice to the obligor.

441—98.73(252B) Method and requirements of reporting. The obligor shall complete Form 470-3155, Report of Seek Employment Activity, which shall be submitted to the unit on a weekly basis throughout the duration of the order unless the obligor has a valid reason for not complying with the order. The obligor shall document at least five new attempts to find employment on the form each week. The same employer may not be reported more than once per week.

The obligor shall include the names, addresses, and the telephone numbers of each of the five employers or businesses with whom the obligor attempted to seek employment and the name of the individual contact to whom the obligor made application for employment or to whom the inquiry was directed.

441—98.74(252B) Reasons for noncompliance. Upon verification, certain conditions shall be considered valid reasons for noncompliance. At the request of the child support recovery unit (CSRU), the obligor shall provide verification of any reason for noncompliance with the order when the information is not available to CSRU through on-line sources. Valid reasons for noncompliance and acceptable verification are:

98.74(1) *Receipt of social security, supplemental security income (SSI), or the family investment program (FIP).* Receipt of social security, SSI, or FIP is considered a valid reason for noncompliance when verified by information contained in on-line sources available to CSRU or written verification from the agency providing the benefits.

98.74(2) *Temporary illness or disability.* Temporary illness or disability of the obligor or other household member is considered a valid reason upon receipt of completed Form 470-3158, Physician's Statement, verifying the obligor's inability to seek or accept employment.

98.74(3) *High school student.* Attending high school is considered a valid reason upon verification from the high school.

98.74(4) *Incarceration.* Incarceration is considered a valid reason when verified through on-line information available to CSRU or on receipt of verification from the institution.

98.74(5) *Substance abuse treatment.* Participating in a supervised substance abuse treatment program that is associated with a treatment center is considered a valid reason upon verification from the treatment center.

98.74(6) *Job training.* Participation in a job training or job seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason upon receipt of verification from the department of employment services.

98.74(7) *Employment or self-employment.* Employment or self-employment is considered a valid reason upon verification through the employer for those employed or through tax documents or business records for those self-employed.

98.74(8) *Payment of support.* Payment on the account equal to the amounts prescribed for income withholding in accordance with rule 441—98.24(252D) throughout the duration of the seek employment order is considered a valid reason upon verification of payments posted to the Iowa collection and reporting (ICAR) system.

441—98.75(252B) Method of service. The seek employment order shall be served on the obligor by regular mail. Proof of service shall be completed in accordance with Iowa Rules of Civil Procedure, Number 82.

441—98.76(252B) Duration of order. The seek employment order shall remain in effect for three months from the date of issuance unless CSRU determines the obligor has a valid reason for noncompliance as specified at rule 441—98.74(252B), at which time the order becomes unenforceable.

Upon acceptance of the reason for noncompliance, CSRU shall notify the obligor that the obligor is no longer required to comply with the seek employment order. Upon denial of the reason for noncompliance, CSRU shall notify the obligor that the obligor shall comply with the existing seek employment order. The notice shall be filed with the clerk of the district court. If the obligor disputes this decision, the obligor shall have recourse through the district court.

These rules are intended to implement Iowa Code section 252B.21.

441—98.77 to **98.80** Reserved.

DIVISION VI
DEBTOR OFFSET

441—98.81(252B) Offset against payment owed to a person by a state agency. The department will make a claim against a payment owed to an obligor by a state agency when support payments are delinquent as set forth in rule 11—40.1(8A). A claim against a payment owed to an obligor shall be applied to court-ordered support which the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.81(1) *Case selection.* The department shall submit to the department of administrative services, at least monthly, a list of obligors who are delinquent at least $50 in support payments.

98.81(2) *Notification of offset.* Within ten days of receiving notification from the department of administrative services that the obligor is entitled to a payment, the department shall:

a. Send a preoffset notice to the obligor. The preoffset notice shall inform the obligor of the amount the department intends to claim and apply to the support obligation and shall contain all information required by Iowa Code subsection 8A.504(2) and 11—subrule 40.4(4).

b. Notify the department of administrative services that the preoffset notice has been sent to the obligor.

98.81(3) *Appeal process.* An obligor may contest the department's claim by submitting a written request to the department. A hearing shall be granted pursuant to rules in 441—Chapter 7 if the obligor's request is submitted within 15 days of the date of the preoffset notice.

98.81(4) *Joint owner.* A joint owner's proportionate share of the payment, as determined by the department of administrative services, shall be released unless other claims are made on that portion of the payment. The department must receive a request for release of a joint owner's share within 15 days of the date of the preoffset notice. The request may be made by either owner.

98.81(5) *Final disposition of offset.* The department shall notify an obligor of the final decision regarding the claim against the offset by sending a final disposition of support recovery claim notice to the obligor.

98.81(6) *Distribution of offset amount.* Offsets shall be applied in accordance with rules 441—95.3(252B) and 441—95.4(252B).

98.81(7) *Percentage of payment offset.* The amount of offset shall be 50 percent of the total payment due the obligor, unless the payment results from lottery winnings, from gambling winnings, or from a payment for a claim under treasurer of state rules on unclaimed property at 781—Chapter 9, in which case the amount of offset shall be 100 percent of the payment. The amount taken shall not exceed the delinquent amount owed by the obligor.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4 and Iowa Code subsection 8A.504(2).

[**ARC 9177B**, IAB 11/3/10, effective 1/1/11]

441—98.82 to **98.90** Reserved.

DIVISION VII
ADMINISTRATIVE LEVY

441—98.91(252I) Administrative levy. When there is a delinquency in an amount equal to the ordered support payable for one month, the child support recovery unit may issue an administrative levy to the obligor's financial institution.

441—98.92 Reserved.

441—98.93(252I) Verification of accounts. The unit may contact a financial institution to obtain verification of the account number, the names and social security numbers listed on the account, and the account balance for an obligor's account. This contact may be by telephone or written communication on Form 470-3170, Asset Verification Form, or by computer printout.

441—98.94(252I) Notice to financial institution. The unit may send a notice to the financial institution with which the account is placed, directing that the financial institution forward to the collection services center all or a portion of the moneys in the obligor's account or accounts on the date the notice is received. The notice shall be sent by first-class mail, with proof of service completed according to rule of civil procedure 82. The notice to the financial institution shall contain all of the information specified in Iowa Code chapter 252I.

441—98.95(252I) Notice to support obligor. The unit shall notify an obligor, and any other party known to have an interest in the account, of the action. The notice shall contain all of the information specified in Iowa Code chapter 252I. The unit shall forward the notice by first-class mail within two working days of sending the notice to the financial institution. Proof of service shall be completed according to Iowa Rules of Civil Procedure 82.

441—98.96(252I) Responsibilities of financial institution. Upon receipt of the notice of administrative levy, the financial institution shall follow procedures specified in Iowa Code section 252I.7 for encumbering and forwarding funds to collection services center. The financial institution shall encumber only the funds in the obligor's account on the day the notice is received. Any deposits made

by the obligor after notice is received by the financial institution are not subject to the administrative levy process unless another notice is issued to the financial institution.

441—98.97(252I) Challenging the administrative levy. An obligor or an account holder of interest may challenge the administrative levy by submitting a written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice to the obligor as specified in rule 441—98.95(252I). Upon receipt of a challenge, the unit shall follow criteria and procedures specified in Iowa Code section 252I.8 for resolving the challenge.

98.97(1) *Review of facts.* The unit shall, upon receipt of a written challenge, review the facts of the case with the challenging party. Only a mistake of fact including, but not limited to, a mistake in the identity of the obligor or a mistake in the amount of delinquent support due shall be considered as a reason to dismiss or modify the proceeding. If the unit determines that a mistake of fact has occurred, the unit shall proceed as follows:

a. If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall notify the financial institution and the obligor that the administrative levy has been released.

b. If the amount of support due was incorrectly overstated, the unit shall notify the financial institution to release the excess moneys to the obligor and remit the remaining moneys.

98.97(2) *Refunds of amounts improperly held.* If a mistake of fact has occurred and money has already been forwarded from the financial institution, the unit shall proceed as follows:

a. If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall refund the funds to the account and reimburse the account for any fees assessed by the financial institution.

b. If the amount of support due was incorrectly overstated, the unit shall refund a portion to the account. The unit is not required to reimburse the account for fees.

98.97(3) *Request for district court hearing.* If no mistake of fact is found, the unit shall send a notice to the challenging party by first-class mail. An obligor or an account holder may submit a second written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice. The unit shall request a hearing before the district court in the county the support order is filed. Procedures for filing a hearing are specified in Iowa Code chapter 252I.

98.97(4) *Request for withdrawal.* The challenging party may withdraw the challenge by submitting a written withdrawal to the person identified as the contact person for the unit in the notice at any time prior to the court hearing. The unit may withdraw the administrative levy at any time prior to the court hearing. The unit shall provide notice of the withdrawal to the financial institution and any account holder of interest by first-class mail.

These rules are intended to implement Iowa Code chapter 252I.

441—98.98 to **98.100** Reserved.

DIVISION VIII
LICENSE SANCTION

441—98.101(252J) Referral for license sanction. In the process referred to as license sanction, the child support recovery unit (CSRU) may refer an individual to a licensing agency for the suspension, revocation, nonissuance, or nonrenewal of a variety of licenses including, but not limited to, motor vehicle registrations, driver's licenses, business and professional licenses, and licenses for hunting, fishing, boating, or other recreational activity. In order to be referred to a licensing agency for license sanction, one of the following must apply:

98.101(1) *Delinquent support payments.* An obligor's support payments must be delinquent in an amount equal to the support payment for three months. CSRU may first refer for license sanction those obligors having the greatest number of months of support delinquency. CSRU shall not refer obligors whose support payments are being made under an income withholding order.

98.101(2) *Subpoena or warrant.* An individual must have failed to comply with a subpoena or warrant, as defined in Iowa Code chapter 252J, relating to a paternity or support proceeding. If a subpoena was issued, the individual must have failed to comply with either Form 470-3413, Child Support Recovery Unit Subpoena, or an Interstate Subpoena as provided in paragraph 96.2(1)*"a"* within 15 days of the issuance of the subpoena, and proof of service of the subpoena was completed according to Rule of Civil Procedure 82.

441—98.102(252J) Reasons for exemption. Certain conditions shall be considered valid reasons for exemption from the license sanction process. Upon verification of these conditions, CSRU shall bypass, exempt, or withdraw the individual's name from referral to licensing agencies for the purpose of applying a license sanction. When the information to verify the exemption is not available to CSRU through on-line sources, CSRU shall request, and the individual shall provide, verification of the reason for exemption. Valid reasons for exemption for failure to comply with a subpoena or warrant and acceptable verification are those listed in subrules 98.102(2), 98.102(3), 98.102(5), and 98.102(6). Valid reasons for exemption for delinquent support payments and acceptable verification are any of the following:

98.102(1) *Receipt of social security, supplemental security income (SSI) or the family investment program (FIP).* Receipt of social security, SSI, FIP, or county assistance (general relief, general assistance, community services, veteran's assistance), based upon the eligibility of the obligor, is considered a valid reason for exemption when verified by information contained in on-line sources available to CSRU or written verification from the agency providing the benefits.

98.102(2) *Temporary illness or disability.* Temporary illness or disability of the individual or illness or disability of another household member which requires the presence of the individual in the home as caretaker is considered a valid reason for exemption upon receipt of a completed Form 470-3158, Physician's Statement, verifying the individual's or household member's inability to work.

98.102(3) *Incarceration.* Incarceration is considered a valid reason for exemption when verified through on-line information available to CSRU or upon receipt of verification from the institution.

98.102(4) *Job training.* Participation in a job-training or job-seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason for exemption upon receipt of verification from the department of employment services or verification through on-line information available to CSRU or upon receipt of a written statement from an income maintenance worker.

98.102(5) *Chemical dependency treatment.* Participation in a chemical dependency treatment program that is licensed by the department of public health or the joint commission on the accreditation of hospitals (JCAH) is considered a valid reason for exemption upon receipt of written verification from the professional staff of the program that participation in the program precludes the individual from working.

98.102(6) *Contempt process.* Involvement in a contempt action dealing with support issues is considered a valid reason for exemption from the license sanction process during the pendency of the contempt action.

441—98.103(252J) Notice of potential sanction of license. When an individual meets the criteria for selection, CSRU may issue a notice to the individual of the potential sanction of any license held by the individual, using Form 470-3278, Official Notice of Potential License Sanction.

98.103(1) *Delinquent support payments.* CSRU shall inform the obligor that the obligor may make immediate payment of all current and past due child support, schedule a conference to review the action of CSRU, or request to enter into a payment agreement with the unit. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

98.103(2) *Subpoena or warrant.* CSRU shall inform the individual that the individual may comply with the subpoena or warrant, or schedule a conference to review the action of CSRU. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

98.103(3) *Certificate of noncompliance.* If an individual fails to respond in writing to the notice within 20 days, or if the individual requests a conference and fails to appear, the unit shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities in accordance with Iowa Code section 252J.3.

441—98.104(252J) Conference.

98.104(1) *Scheduling of conference.* Upon receipt from an individual of a written request for a conference, CSRU shall schedule a conference not more than 30 days in the future. At the request of either CSRU or the individual, the conference may be rescheduled one time. When setting the date and time of the conference, if notice was sent to an obligor under subrule 98.103(1), CSRU shall request the completion of Form 470-0204, Financial Statement, and other financial information from both the obligor and the obligee as may be necessary to determine the obligor's ability to comply with the support obligation.

98.104(2) *Payment calculation.* If notice was sent to an obligor under subrule 98.103(1) during the conference held in compliance with the provisions of Iowa Code section 252J.4, CSRU shall determine if the obligor's ability to pay varies from the current support order by applying the mandatory supreme court guidelines as contained in 441—Chapter 99, Division I, with the exception of subrules 99.4(3) and 99.5(5). If further information from the obligor is necessary for the calculation, CSRU may schedule an additional conference no less than ten days in the future in order to allow the obligor to present additional information as may be necessary to calculate the amount of the payment. If, at that time, the obligor fails to provide the required information, CSRU shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities. If the obligee fails to provide the necessary information to complete the calculation, CSRU shall use whatever information is available. If no income information is available for the obligee, CSRU shall determine the obligee's income in accordance with 441—subrules 99.1(2) and 99.1(4). This calculation is for determining the amount of payment for the license sanction process only, and does not modify the amount of support obligation contained in the underlying court order.

98.104(3) *Referral for review and adjustment.* If the amount calculated in subrule 98.104(2) meets the criteria for review and adjustment as specified in rule 441—99.62 (252B,252H), or administrative modification as specified in rule 441—99.82(252H) and 441—subrules 99.83(1), 99.83(2) and 99.83(6) at the time CSRU provides the payment agreement to the obligor, CSRU shall also provide the obligor with any necessary forms to request a review and adjustment or administrative modification of the support obligation. The payment agreement remains in effect during the review and adjustment or administrative modification process.

441—98.105(252J) Payment agreement. The License Sanction Payment Agreement, Form 470-3273, shall require the obligor to pay the lower of the amount calculated in subrule 98.104(2) or the maximum amount payable under an income withholding order as specified in rule 98.24(252D).

98.105(1) *Duration of payment agreement.* The License Sanction Payment Agreement signed under this division shall remain in effect for at least one year from the date of issuance unless CSRU determines the obligor has a valid reason for exemption as specified in rule 98.102 (252J). Except in those cases in which review and adjustment are in process, CSRU may, at the end of the year, begin the process of reviewing the case to ensure that the payment amount continues to accurately reflect the obligor's ability to pay as calculated in subrule 98.104(1).

98.105(2) *Failure to comply.* If at any time following the signing of a payment agreement the obligor fails to comply with all the terms of the agreement, CSRU shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities in accordance with the provisions of Iowa Code chapter 252J.

441—98.106(252J) Staying the process due to full payment of support. If the obligor, at any time, pays the total support owed, both current and past due, or an individual complies with the subpoena or warrant, CSRU shall stay the process, and any Certificate of Noncompliance, Form 470-3274, which has been issued shall be withdrawn by CSRU.

441—98.107(252J) Duration of license sanction. The Certificate of Noncompliance, Form 470-3274, shall remain in effect until the obligor pays all support owed, both arrears and current; or the obligor enters into a payment agreement with CSRU; or the obligor meets one of the criteria for exemption specified at subrules 98.102(1), 98.102(2), and 98.102(4); or the individual complies with the subpoena or warrant.

These rules are intended to implement Iowa Code chapter 252J as amended by 1997 Iowa Acts, House File 612, division X.

441—98.108 to **98.120** Reserved.

DIVISION IX
EXTERNAL ENFORCEMENT

PREAMBLE

This division implements provisions of 1997 Iowa Acts, House File 612, sections 35 and 244, which provide for enforcement of child support arrearages by external sources. These sources are entities under contract to collect difficult-to-collect arrearages and private attorneys acting independently of the unit but with the unit's consent. The rules provide criteria and procedures for referral of delinquent support to collection contractors, assessment of the statutory surcharge, and opportunity for the delinquent parent to contest. The rules also provide a procedure to allow state payment to private attorneys enforcing child support recovery unit (CSRU) cases and provide criteria to exempt cases from the procedure.

441—98.121(252B) Difficult-to-collect arrearages. The child support recovery unit may refer difficult-to-collect arrearages to a collection entity under contract with the unit or with another state entity. Upon referral, a surcharge, in addition to the support, shall be due and payable by the obligor as provided in 1997 Iowa Acts, House File 612, section 244.

98.121(1) *Difficult-to-collect arrearage.* A difficult-to-collect arrearage is one based upon a court or administrative order which meets all the following criteria:

a. There is no order for current support and only an arrearage is owing.

b. There has been no payment, except for federal or state tax refund offset payments, in the past three months.

c. There is no valid reason for exemption from the referral and surcharge process. Valid reasons for exemption and acceptable verification are those listed in subrules 98.102(1), 98.102(3), and 98.102(6). Upon verification of those conditions, the child support recovery unit shall bypass or exempt the obligor's arrearages from the referral and surcharge process. When the information to verify the exemption is not available to the child support recovery unit through on-line sources, the child support recovery unit shall request, and the obligor shall provide, verification of the reason for exemption.

98.121(2) *Notice of the possibility of referral and surcharge.* The child support recovery unit shall provide notice of the possibility of a referral and surcharge to the obligor as required by 1997 Iowa Acts, House File 612, section 244. The notice shall be provided at least 15 days before the unit sends the notice of referral and surcharge to the obligor, subject to the following:

a. *Notification contained in order.* When the support order under which the arrearage has accrued contains language advising of statutory provisions for referral and surcharge, no other preliminary notice shall be required.

b. *Notification issued by the child support recovery unit.* When the support order under which the arrearage has accrued does not contain language regarding the statutory provisions for referral and surcharge, or was entered under a foreign jurisdiction and notification was not included in the support order or provided as a separate written notice, the child support recovery unit shall issue Form 470-3412, Legal Notice of Referral and Surcharge, to the obligor. The notice shall be sent by regular mail to the obligor's last-known address.

98.121(3) *Notice of referral and surcharge.* The child support recovery unit shall send notice of a referral and surcharge to the obligor by regular mail to the obligor's last-known address, with proof of service completed according to Rule of Civil Procedure 82. The notice shall contain all the information required by 1997 Iowa Acts, House File 612, section 244. The notice shall be sent at least 30 days before the unit refers the arrearage to the collection entity.

98.121(4) *Contesting the referral and surcharge.* An obligor may contest the referral and surcharge. The right to contest is limited to a mistake of fact including but not limited to a mistake in the identity of the obligor, a mistake as to whether there was a payment in the three months before the date of the notice specified in subrule 98.121(3), a mistake as to whether an exemption in paragraph 98.121(1)*"c"* applies, or a mistake in the amount of arrearages.

a. An obligor may contest the referral and surcharge by submitting a written request for a review to the unit within 20 days of the date on the notice of referral and surcharge specified in subrule 98.121(3). Upon receipt of a written request for review, the unit shall follow the criteria and procedures specified in 1997 Iowa Acts, House File 612, section 244, for resolving the request.

(1) If the unit determines there is a mistake in the identity of the obligor, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the unit shall issue a written notice to the contestant or obligor of the determination and not refer the arrearages. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the unit determines there was a mistake in the amount of arrearages, but the corrected amount of arrearages will still be referred, or if the unit determines there is no mistake of fact, the unit shall issue a written notice of the determination of the review to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearages that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting an additional review by the bureau chief, and on requesting a judicial hearing. For purposes of this rule, bureau chief shall mean "bureau chief" as defined in rule 441—95.1(252B).

b. An obligor may contest the notice of determination of review by submitting a written request for an additional review by the bureau chief within 20 days of the date of the notice of determination of the review issued under paragraph *"a."* Upon receipt of the written request for additional review, the bureau chief shall review the facts of the case.

(1) If the bureau chief determines a mistake in the identity of the obligor has occurred, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the bureau chief shall issue a written notice to the contestant or obligor of the determination and the arrearages shall not be referred. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the bureau chief determines that there was a mistake in the amount of the arrearage but the corrected amount of arrearages will still be referred, or if there is no mistake of fact, the bureau chief shall send a written notice of the additional review determination to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearage that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting a judicial hearing.

c. Following the issuance of a notice of determination of a review under paragraph *"a,"* or issuance of a notice of determination of an additional review under paragraph *"b,"* the obligor may request a district court hearing. The obligor shall make a request by sending a written request for a hearing to the unit within ten days of the date of the unit's written determination of the review, or within ten days of the date of the bureau chief's written determination of an additional review, whichever is later. Procedures for a district court hearing are specified in 1997 Iowa Acts, House File 612, section 244.

d. The unit shall not refer arrearages and assess a surcharge until after completion of any review, additional review or judicial hearing process.

98.121(5) *Referral and surcharge.*

a. If the obligor has not paid the arrearage, has not contested the referral, or if, following the unit's review, the bureau chief's additional review, and any judicial hearing, the unit, bureau chief, or court does not find a mistake of fact, the arrearage shall be referred to the collection entity.

b. The amount of the arrearage referred shall be the amount that is unpaid as of the date of the referral. The amount of the surcharge shall be an amount equal to the amount of the arrearage unpaid as of the date of the referral, multiplied by the percentage specified in the contract with the collection entity.

c. The child support recovery unit shall file Form 470-3411, Notice of Surcharge, with the clerk of the district court in the county in which the underlying support order is filed.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 244.

441—98.122(252B) Enforcement services by private attorney entitled to state compensation. An attorney licensed to practice law in Iowa may utilize judicial proceedings to collect support, at least a portion of which is assigned support, and be entitled to compensation by the state as provided in 1997 Iowa Acts, House File 612, section 35.

98.122(1) *Eligible cases.* To be eligible for attorney services with compensation under this rule, a case must meet all of the following:

a. The child support recovery unit is providing services under Iowa Code chapter 252B.

b. The current support obligation is terminated and only arrearages are due under the administrative or court order.

c. There has been no payment under any order in the case for at least a 12-month period prior to the provision of the notice from the attorney to the unit under paragraph *"f."*

d. At least a portion of the arrearages due under any order in the case is assigned to the state because cash assistance was paid under 1997 Iowa Acts, Senate File 516, sections 2 through 24 and 35.

e. The case does not have any of the following characteristics:

(1) There has been a finding of good cause or other exception pursuant to Iowa Code section 252B.3 as amended by 1997 Iowa Acts, House File 612, section 26.

(2) A portion of the arrears is assigned to another state because of public assistance provided by that state.

(3) Another attorney has already notified the unit of the intent to initiate a judicial proceeding to collect support due under any order in the same case under this rule, and either the time to receive the collection has not expired or the unit has not received a notice from the other attorney that the judicial proceeding has concluded prior to the expiration of the time period.

(4) If the notice from the attorney under paragraph *"f"* specifies contempt of court as the judicial proceeding, and the unit has generated a seek employment order to the obligor under Iowa Code section 252B.21 less than nine months prior to the date on the notice from the attorney.

(5) The case or arrearages have been referred by the child support recovery unit to a collection entity under Iowa Code section 252B.5, subsection 3, as amended by 1997 Iowa Acts, House File 612, section 30, or 1997 Iowa Acts, House File 612, section 244, less than nine months prior to the date on the notice from the attorney.

(6) The obligor has filed for bankruptcy and collection activities are stayed.

(7) The notice from the attorney under paragraph *"f"* lists a specific judicial proceeding and the unit has already initiated the same type of proceeding in court.

(8) The case has been referred to the U.S. Attorney's office and is still pending at that office.

f. The attorney has provided written notice to the central office of the child support recovery unit in Des Moines, as specified in subrule 98.122(2), and to the last-known address of the obligee of the intent to initiate a specified judicial proceeding to collect support on any identified court or administrative order involving the obligor and obligee in the case.

g. The attorney has provided documentation of insurance to the unit as required by 1997 Iowa Acts, House File 612, section 35.

h. The collection must be received by the collection services center within 90 days of the notice from the attorney in paragraph *"f,"* or within a subsequent 90-day extension period.

98.122(2) *Procedure.*

a. To begin the process under this rule, the attorney shall submit the following to the External Services Process Specialist, Bureau of Collections, Iowa Department of Human Services, Hoover Building, Fifth Floor, Des Moines, Iowa 50319-0114 at least 30 days prior to initiating the specified judicial proceeding:

(1) A dated, written statement which lists the specific judicial proceeding which the attorney intends to initiate, any court or administrative order under which the arrearages accrued identified by the order number, and the names of the obligor and obligee.

(2) Documentation that the attorney is insured as required by the statute. Documentation shall be either a copy of the attorney's policy from the insurer, or a letter from the insurer verifying insurance coverage as required by the statute.

(3) Documentation that the attorney is licensed to practice law in Iowa.

b. The unit shall mail a response to the attorney within ten days of receipt of the notice from the attorney. All of the following shall apply to the unit's response:

(1) If the case meets the requirements of this rule, the notice shall list the case number, any order numbers, the judicial proceeding specified by the attorney, the balance due the state of Iowa, the balance due an obligee, and the date that is 90 days from the date of the notice from the attorney. The notice shall also contain a statement that any compensation due the attorney as a result of application of this rule will be calculated on the amount of support credited to arrearages due the state at the time the support paid as a result of the judicial proceeding is received by the collection services center. The notice shall also contain a statement that any support collected shall be disbursed in accordance with federal requirements, and any support due the obligee shall be disbursed to the obligee prior to disbursement to the attorney as compensation.

(2) If the case does not meet the requirements of this rule, the notice shall list the case number, any order number, and the reason the case does not meet the requirements.

c. If the case is eligible under this rule, the attorney may initiate judicial proceedings after 30 days after providing the notice to child support recovery unit in paragraph *"a."* Section 35 of 1997 Iowa Acts, House File 612, defines "judicial proceedings."

d. The attorney may extend the time to complete the judicial proceeding or to allow for receipt of the collection by the collection services center by submitting a notice requesting a 90-day extension to the address in paragraph *"a."* This or any subsequent notice must be received by the unit before expiration of the current 90-day time frame. The child support recovery unit shall acknowledge receipt of the subsequent notice and list on the acknowledgment the date that is 90 days from the date of the attorney's subsequent notice.

98.122(3) *Collection and payment to attorney.*

a. Upon compliance with the requirements of 1997 Iowa Acts, House File 612, section 35, and this rule, the attorney shall be entitled to compensation from the state as provided for in this rule.

b. Upon receipt of a file-stamped copy of a court order which identifies the amount of support collected as a result of the judicial proceeding and which does not order the payment of attorney fees by the obligor, and the receipt of the collection by the collection services center, all the following apply:

(1) Section 35 of 1997 Iowa Acts, House File 612, specifies the formula to calculate the compensation due the attorney from the state. The child support recovery unit shall calculate the compensation due the attorney based upon the amount of support which is credited to arrearages due the state at the time the collection is received by the collection services center. After calculating the amount due the attorney, the unit shall reduce the amount due the attorney by the amount of any penalty or sanction imposed upon the state as a result of any other judicial proceeding initiated by that attorney under 1997 Iowa Acts, House File 612, section 35. The child support recovery unit shall send the attorney a notice of the amount of the compensation due from the state.

(2) The collection services center shall disburse any support due an obligee prior to payment of compensation to the attorney.

(3) The child support recovery unit shall not authorize disbursement of compensation to the attorney until the later of 30 days after receipt of the collection and the file-stamped copy of the order, or resolution of any timely appeal by the obligor or obligee.

(4) The amount of compensation due the attorney is subject to judicial review upon application to the court by the attorney.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 35.

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[1]See 2005 Iowa Acts, Senate File 350, section 20.
[2]See 2007 Iowa Acts, chapter 218, sections 186 and 187, and 2008 Iowa Acts, chapter 1019, section 18 (rule nullified effective July 1, 2009).

CHAPTER 99
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

PREAMBLE

This chapter contains rules governing the provision of services by the child support recovery unit regarding: the establishment of paternity; the establishment of support obligations in accordance with the mandatory guidelines set by the Iowa Supreme Court; the review and adjustment of support obligations; the modification of support obligations; and the suspension and reinstatement of support obligations. The rules in this chapter pertain only to administrative actions or procedures used by the unit in providing the services identified. This chapter shall not be interpreted to limit the unit's authority to use other means as provided for by state or federal statute, including, but not limited to, judicial procedures in providing these services.

DIVISION I
CHILD SUPPORT GUIDELINES

441—99.1(234,252B,252H) Income considered. The child support recovery unit shall consider all regularly recurring income of both legal parents to determine the amount of the support award in accordance with the child support guidelines prescribed by the Iowa Supreme Court. These rules on child support guidelines shall not apply if the child support recovery unit is determining the support amount by a cost-of-living alteration as provided in Iowa Code chapter 252H, subchapter IV.

99.1(1) *Exempt income.* The following income of the parent is exempt in the establishment or modification of support:

a. Income received by the parent under the family investment program (FIP).

b. Income or other benefits derived from public assistance programs funded by a federal, state, or local governmental agency or entity that are listed in rule 441—41.27(239B) as exempt from consideration in determining eligibility under FIP.

c. Income such as child support, social security dependent benefits received by a parent for a child because of the other parent's disability, and veteran's dependent benefits received by a parent on behalf of a child.

d. Stepparent's income.

e. Income of a guardian who is not the child's parent.

f. Income of the child's siblings.

g. Earned income tax credit.

99.1(2) *Determining income.* Any of the following may be used in determining a parent's income for establishing or modifying a support obligation:

a. Income reported by the parent in a financial statement.

b. Income established by any of the following:

(1) Income verified by an employer or other source of income.

(2) Income reported to the department of workforce development.

(3) For a public assistance recipient, income reported to the department of human services caseworker assigned to the public assistance case.

(4) Other written documentation that identifies income.

c. Income as determined through occupational wage rate information published by the Iowa workforce development department or other state or federal agencies.

d. The median income for parents on the CSRU caseload, calculated annually.

e. Social security dependent benefits. Social security dependent benefits paid for a child because of a parent's disability shall be included in the disabled parent's income. Social security dependent benefits paid for a parent due to the other parent's disability shall be included in the receiving parent's income.

99.1(3) *Verification of income.* Verification of income and allowable deductions from each parent shall be requested.

a. Verification of income may include, but is not limited to, the following:

(1) Federal and state income tax returns.

(2) W-2 statements.

(3) Pay stubs.

(4) Signed statements from an employer or other source of income.

(5) Self-employment bookkeeping records.

(6) Award letters confirming entitlement to benefits under a program administered by a government or private agency such as social security, veterans' or unemployment benefits, military or civil service retirement or pension plans, or workers' compensation.

b. Cases in which the information or verification provided by a parent is questionable or inconsistent with other circumstances of the case may be investigated. If the investigation does not reveal any inconsistencies, the financial statement and other documentation provided by the parent shall be used to establish income.

c. If discrepancies exist in the financial statement provided by the parent and additional income information is not available, the child support recovery unit may:

(1) Request a hearing before the court if attempting to establish a support order through administrative process.

(2) Conduct discovery if a parent places the matter before the court by answering a petition or requesting a hearing before the court.

(3) When attempting to establish a default order, provide the court with a copy of the parent's financial information and the reasons the information may be questionable.

d. If the child support recovery unit is unable to obtain verification of a parent's income, the financial statement provided by the parent may be used to establish support.

99.1(4) *Use of occupational wage rate information or median income for parents on the CSRU caseload.* Occupational wage rate information or median income for parents on the CSRU caseload shall be used to determine a parent's income when the parent has failed to return a completed financial statement when requested, and when complete and accurate income information from other readily available sources cannot be secured.

a. *Occupation known.* When the last-known occupation of a parent can be determined through a documented source including, but not limited to, Iowa workforce development or the National Directory of New Hires, occupational wage rate information shall be used to determine income. When the last-known occupation of a parent cannot be determined through a documented source, information may be gathered from the other parent and occupational wage rate information applied. Wage rate information shall be converted to a monthly amount in accordance with subrule 99.3(1).

b. *Occupation unknown.* When the occupation of a parent is unknown, CSRU shall estimate the income of a parent using the median income amount for parents on the CSRU caseload.

99.1(5) *Self-employment income.* A self-employed parent's adjusted gross income, rather than the net taxable income, shall be used in determining net income. The adjusted gross income shall be computed by deducting business expenses involving actual cash expenditures that affect the actual dollar income of the parent.

a. A person is self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service (IRS).

b. In calculating net income from self-employment, the child support recovery unit shall deduct only those items allowed by the child support guidelines. Amounts from a prior period claimed as net losses shall not be allowed as deductions.

c. Net profits from self-employment may be determined through a review of self-employment bookkeeping records, sales and expenditure records, quarterly reports filed with the IRS, previous year's federal or state income tax returns, or other documentation. The parent shall provide records of

bookkeeping, sales, and expenditures for the most recent 12-month period or, if the self-employment is less than 12 months old, for the period since the self-employment began.

99.1(6) *Fluctuating income.* A person has a fluctuating income when the calculated gross income or the adjusted gross income, as defined in subrule 99.1(5), for the current year varies from the gross or adjusted gross income of the previous year by more than 20 percent.

a. If requested, the child support recovery unit shall average the income of a person whose income fluctuated because the nature of the person's occupation is of a type that normally experiences fluctuations in income.

b. In determining a person's average income, the following procedures shall be used:

(1) For non-self-employed persons, the child support recovery unit shall estimate the gross income for the current year and add the amount to the gross income from relevant years that would accurately depict fluctuations in the person's income. The unit shall divide this sum by the number of years added, prior and current, to arrive at an average gross annual income. The unit shall divide the average gross annual income by 12 to arrive at the person's average gross monthly income.

(2) For income from self-employment, the child support recovery unit shall compute the adjusted gross annual income as defined in subrule 99.1(5) for the relevant years that would accurately depict fluctuations in the person's income. The unit shall use the adjusted gross annual income to compute the average adjusted gross monthly income in the same manner as the computation of average gross monthly income in 99.1(6)*"b"*(1).

441—99.2(234,252B) Allowable deductions. The deductions specified in the supreme court child support guidelines shall be allowed when determining the amount of income subject to application of the guidelines. The parent claiming the deduction shall provide the documentation necessary for computing allowable deductions. Allowable deductions are:

99.2(1) Federal and state income tax.

a. The child support recovery unit shall calculate the amount of the deduction for federal and state income tax as specified in the Iowa Supreme Court guidelines.

b. The unit shall calculate the amount of the deduction for self-employed persons with fluctuating incomes, as defined in subrule 99.1(6), by computing the person's averaged income and applying the method of calculating a tax deduction as required by Iowa Supreme Court guidelines.

99.2(2) Social security and Medicare tax deductions, mandatory pensions, and union dues as specified in the Iowa Supreme Court guidelines.

99.2(3) Mandatory occupational license fees as specified in the Iowa Supreme Court guidelines.

99.2(4) Actual payments of child and spousal support pursuant to a prior court or administrative order. The date of the original court or administrative order, rather than the date of any modifications, shall establish a prior order under this subrule. Support paid under an order established subsequent to the order being modified shall not be deducted. All support payments shall be verified before being allowed as a deduction. The child support recovery unit shall calculate deductions for support as follows:

a. In establishing prior support payments, the child support recovery unit shall verify payments made for the 12 months preceding the month in which the amount of support for the new order is determined. If the support obligation is less than one year old, the child support recovery unit shall verify each monthly payment since the beginning of the obligation.

b. If the obligation is one year old or older, the child support recovery unit shall add together all verified amounts paid during the past 12 months up to the total of the current support obligation that accrued during this 12-month period, and divide by 12. All amounts collected shall be included, regardless of the source.

c. If the support obligation is less than one year old, the child support recovery unit shall add together the verified amounts paid since the obligation began up to the total of the current support obligation that accrued during this period, and divide by the number of months that the obligation has existed.

d. When a parent has more than one prior support order, the child support recovery unit shall calculate the allowable deduction for each obligation separately, and then add the amounts together to determine the parent's total allowable deduction.

99.2(5) Actual medical support paid pursuant to a court order or administrative order in another order for other children, not the pending matter. All medical support payments shall be verified before being allowed as a deduction and shall be calculated in the same manner as the deductions for support in subrule 99.2(4).

99.2(6) Actual child care expenses during the custodial parent's employment, less the applicable federal income tax credit. The child support recovery unit shall determine the amount of the child care deduction as follows:

a. Actual child care expenses related to the custodial parent's employment shall be verified by a copy of the custodial parent's federal or state income tax return or by a signed statement from the person or agency providing the child care.

b. Only the amount of reported child care expenses in excess of the amount allowed as "credit for child and dependent care expenses" for federal income tax purposes shall be allowed as a deduction in determining the custodial parent's net income.

c. In determining the deduction allowed to the custodial parent for child care expenses due to employment, the following procedures shall be used:

(1) If the custodial parent provides a copy of a federal income tax return for the current tax processing year and the amount is consistent with the current financial circumstances of the parent, the child support recovery unit shall use the amount reported as "credit for child and dependent care expenses."

(2) If income tax information is not available, or if the parent indicates or there is reason to believe that the amount stated in the return is no longer representative of the parent's financial conditions or child care expenses, the child support recovery unit shall determine the allowable deduction for child care expenses for federal income tax purposes using the custodial parent's income only.

d. The child support recovery unit shall compute the child care deduction as follows:

(1) Divide the amount of child care expense the parent may claim as a deduction for federal income tax purposes by 12 to arrive at a monthly amount.

(2) If the child care expense reported on the financial statement is not a monthly amount, convert the reported amount to an equivalent monthly figure and round the figure to two decimal places.

(3) Subtract the amount the parent may claim as "credit for child and dependent care expenses" for federal income tax from the amount of child care expenses reported on the financial statement. The difference is the amount allowed for a deduction in determining income for child support.

99.2(7) Qualified additional dependent deduction (QADD). The qualified additional dependent deduction is the amount specified in the supreme court guidelines as a deduction for any child for whom parental responsibility has been legally established as defined by the child support guidelines. However, this deduction may not be used for a child for whom the parent may be eligible to take a deduction under subrule 99.2(4).

a. The deduction for qualified additional dependents may be used:

(1) For dependents of the custodial or noncustodial father or mother, whether in or out of the parent's home. The father may establish the deduction by providing written verification of a legal obligation to the children through one of the actions enumerated in the guidelines. The mother may establish the deduction by providing written verification of a legal obligation to the children, including the mother's statement.

(2) In the establishment of original orders.

(3) In the modification of existing orders. The deduction may be used in an upward modification. The deduction cannot be used to affect the threshold determination of eligibility for a downward modification, but may be used after the threshold determination is met.

b. Reserved.

99.2(8) Cash medical support as specified in the Iowa Supreme Court guidelines.

[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.3(234,252B) Determining net income. Unless otherwise specified in these rules, the child support recovery unit shall determine net income as prescribed by the Iowa Supreme Court guidelines.

99.3(1) *Calculating net income.* All includable income and allowable deductions shall be expressed in monthly amounts. Income and corresponding deductions received at a frequency other than monthly shall be converted to equivalent monthly amounts by multiplying the income and corresponding deductions received on a weekly basis by 4.33, on a biweekly basis by 2.17, and on a semimonthly basis by 2.

99.3(2) *Estimating net income.*

a. The estimated net income of a parent shall be 80 percent of the reported income or the estimated income as determined from occupational wage rate information or derived from the median income of parents on the CSRU caseload, as appropriate, minus the deductions enumerated in subrules 99.2(3) to 99.2(8) when the information to calculate these deductions is readily available through automated or other sources.

b. The net income of a parent shall be estimated under the following conditions:

(1) Gross earned income information was obtained from a source that did not provide itemized deductions allowed by the mandatory support guidelines.

(2) Occupational wage rate information or median income of parents on the CSRU caseload was used to determine a parent's income.

[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.4(234,252B) Applying the guidelines.

99.4(1) *Applying the guidelines.* The child support recovery unit shall use the child support guidelines schedule as prescribed by the Iowa Supreme Court only for the number of children for whom support is being sought sharing the same two legal parents.

EXCEPTION: For foster care recovery cases, the guidelines schedule shall be used as set forth in subrule 99.5(4).

99.4(2) *Establishing current support.*

a. *Calculation.* The child support recovery unit shall calculate the amount of support as prescribed by the Iowa Supreme Court guidelines. Round amount of support to the nearest whole dollar.

b. *Additional factors.*

(1) In all cases other than foster care, CSRU shall establish current support payable in monthly frequencies.

(2) In foster care cases, CSRU may establish current support payable in monthly or weekly frequencies. To establish a weekly amount, CSRU shall divide the figure in paragraph 99.4(2)*"a"* by 4.33 and round to the nearest whole dollar.

(3) If the court orders joint (equally shared) physical care of a child or split or divided physical care of multiple children, the unit shall calculate current support according to the Iowa Supreme Court guidelines for each parent assuming the other is the custodial parent. If a child begins receiving family investment program (FIP) benefits or if foster care funds are expended, an offset of the two amounts as a method of payment shall be disallowed.

(4) The amount of support shall be zero if the noncustodial parent's only income is Supplemental Security Income paid pursuant to 42 U.S.C. 1381a.

99.4(3) *Establishing accrued support debt amount.*

a. Support debt created. The payment of public assistance to or for the benefit of a dependent child or a dependent child's caretaker creates an accrued support debt due and owing by the child's parent to the department. The amount of the accrued support debt is based on the period of time public assistance payment or foster care funds were expended, but is not created for the period of receipt of public assistance on the parent's own behalf for the benefit of the dependent child or the child's caretaker.

b. Calculating accrued support debt. CSRU shall calculate the accrued support debt as follows:

(1) For Family Investment Program (FIP) benefits, CSRU shall use the period for which FIP was paid during the 36 months preceding the date the notice of support debt is prepared or the date the petition is filed. For foster care assistance, CSRU shall use the three-month period for which foster care assistance

was paid prior to the date the initial notice to the noncustodial parent of the amount of support obligation is prepared, or the date a written request for a court hearing is received, whichever is earlier.

(2) CSRU shall exclude periods the noncustodial parent received public assistance as a part of this eligible group.

(3) CSRU may extend the period to include any additional periods public assistance is expended prior to the entry of the order.

(4) CSRU shall calculate the amount of the obligation by using the current net income of both parents, the guidelines in effect at the time the order is entered, and the number of children of the noncustodial parent who were receiving public assistance for each month for which accrued support is sought.

(5) CSRU shall calculate the total amount of the FIP support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount.

(6) CSRU may calculate the total amount of the foster care support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount and shall adjust this amount for weeks in which no foster care benefits were paid.

c. Establishing the accrued support repayment amount.

(1) In cases other than foster care, CSRU shall establish the repayment amount as follows:

1. When there is an ongoing obligation, the monthly repayment amount shall be 10 percent of the ongoing amount unless the noncustodial parent agrees to a higher amount.

2. When the order does not include ongoing support, the monthly repayment amount shall be the same as the amount for ongoing support which would have been due if such an obligation had been established. However, when all of the children for whom accrued support debt is sought are residing with the noncustodial parent, the monthly repayment amount shall be set at 10 percent of this amount.

(2) In foster care cases, CSRU shall establish the repayment amount in the same manner as subparagraph (1), but may establish weekly amounts and if the order does not include ongoing support, the repayment amount shall be set at 10 percent of the amount for ongoing support which would have been due if such an obligation had been established.

99.4(4) *Children in nonparental homes or foster care.* The parents of a child in a nonparental home or in foster care are severally liable for the support of the child. A support obligation shall be established separately for each parent.

a. Parents' location known. When the location is known for both parents having a legal obligation to provide support for their children, the income of both parents shall be used to determine the amount of ongoing support in accordance with the child support guidelines.

(1) Calculating support amount. There shall be a separate calculation of each parent's child support amount, regardless of whether the parents are married and living together, or living separately. Each calculation shall assume that the parent for whom support is being calculated is the noncustodial parent and the other parent is the custodial parent.

(2) Prior orders. If only one parent is paying support under a prior order for the children for whom support is being calculated, the amount of support paid shall not be deducted from that parent's net monthly income in computing the support amount for the other parent.

b. One parent's location unknown. When the location of one parent is not known, procedures shall be initiated to establish a support order against the parent whose location is known in accordance with the mandatory support guidelines as follows:

(1) The parent whose location is known shall be considered the noncustodial parent and that parent's income shall be used to calculate child support.

(2) The income of the parent whose location is unknown shall be determined by using the estimated median income for parents on the CSRU caseload and that parent shall be considered the custodial parent in calculating child support.

c. When one parent is deceased or has had parental rights terminated, the method used to calculate support when one parent's location is not known shall be used. The parent who is deceased or has had parental rights terminated shall be considered the custodial parent with zero income.

99.4(5) *Extraordinary visitation adjustment.* The extraordinary visitation adjustment is a credit as specified in the supreme court guidelines. The credit shall not reduce the child support below the amount required by the supreme court guidelines.

The extraordinary visitation adjustment credit shall be given if all of the following apply:

a. There is an existing order for the noncustodial parent that meets the criteria for extraordinary visitation in excess of 127 overnights per year on an annual basis for the child for whom support is sought. The order granting visitation can be a different order than the child support order. If a controlling order is determined pursuant to Iowa Code chapter 252K and that controlling support order does not meet the criteria for extraordinary visitation, there is another order that meets the criteria.

b. The noncustodial parent has provided CSRU with a file-stamped or certified copy of the order.

c. The court has not ordered equally shared physical care.

99.4(6) *Establishing medical support.* The child support recovery unit shall calculate medical support as required by Iowa Code chapter 252E and the Iowa Supreme Court guidelines. The cost of the health insurance premium for the child is added to the basic support obligation and prorated between the parents as provided in the Iowa Supreme Court guidelines, and the parent ordered to provide health insurance must provide verification of this expense or anticipated expense.

[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.5(234,252B) Deviation from guidelines.

99.5(1) *Criteria for deviation.* The court shall not vary from the amount of child support that would result from application of the guidelines without a written finding as required by the Iowa Supreme Court guidelines.

99.5(2) *Supporting financial and legal documentation.*

a. The party requesting a deviation from the guidelines shall provide supporting documentation. The supporting documentation shall include an itemized list identifying the amount and nature of each adjustment requested. Failure to provide supporting documentation for a request for deviation shall result in a denial of the request.

b. Legal documents prepared for the court's approval, such as stipulations and orders for support, shall include language to identify the following:

(1) The amount of support calculated under the guidelines without allowance for deviations.

(2) The reasons for deviating from the guidelines.

(3) The amount of support calculated after allowing for the deviation.

99.5(3) *Depreciation.* A parent may request a deduction for depreciation of machinery, equipment, or other property used to earn income. Straight-line depreciation shall be the only type of depreciation that shall be allowed as a deduction. The child support recovery unit shall allow the straight-line depreciation amount as a deduction if the parent provides documentation from a tax preparer verifying the amount of straight-line depreciation being claimed. Straight-line depreciation is computed by deducting the property's estimated salvage value from the cost of the property, and deducting that figure in equal yearly amounts over the period of the property's remaining estimated useful life.

99.5(4) *Foster care case.* In a foster care case, the child support recovery unit may deviate from the guidelines by applying a 30 percent flat rate deduction for parents who provide financial documentation. The flat rate deduction represents expenses under the case permanency plan and financial hardship allowances or other circumstances contemplated in Iowa Code section 234.39.

CSRU shall calculate the support obligation of the parents of children in foster care when the parents have a legal obligation for additional dependents in the home, as follows: The support obligation of each parent shall be calculated by allowing all deductions the parent is eligible for under the child support guidelines as provided in rule 441—99.2(234,252B) and by using the guidelines schedule corresponding to the sum of the children in the home for whom the parent has a legal obligation and the children in foster care. The calculated support amount shall be divided by the total number of children in foster care and in the home to compute the support obligation of the parent for each child in foster care.

99.5(5) *Negotiation of accrued support debt.* The child support recovery unit may negotiate with a parent to establish the amount of accrued support debt owed to the department. In negotiating accrued

support, the state does not represent the custodial parent. The custodial parent may intervene at any time prior to the filing of the order to contest the amount of the debt or request the entry of a judgment in the parent's behalf which may otherwise be relinquished through negotiation or entry of a judgment.
[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

These rules are intended to implement Iowa Code sections 234.39, 252B.3, 252B.5, 252B.7A, and 598.21(4).

441—99.6 to **99.9** Reserved.

DIVISION II
PATERNITY ESTABLISHMENT
PART A
JUDICIAL PATERNITY ESTABLISHMENT

441—99.10(252A) Temporary support. If a court ordered a putative father to pay temporary support before entering an order making a final determination of paternity under Iowa Code section 252A.6A, but then the court determines that the putative father is not the legal father and enters an order terminating the temporary support, all the following apply.

99.10(1) *Satisfaction of accrued support.* Upon receipt of a file-stamped copy of the order terminating the support order, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:

a. The child support recovery unit shall satisfy only unpaid support assigned to the department.

b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver or notice, the child support recovery unit is not prevented from satisfying amounts due the department.

c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court.

99.10(2) *Previously collected moneys.* The child support recovery unit shall not return any moneys previously paid on the temporary support judgment.

This rule is intended to implement Iowa Code section 252A.6A.

441—99.11 to **99.20** Reserved.

PART B
ADMINISTRATIVE PATERNITY ESTABLISHMENT

441—99.21(252F) When paternity may be established administratively. The child support recovery unit may seek to administratively establish paternity and accrued or accruing child support and medical support obligations against an alleged father when the conditions specified in Iowa Code chapter 252F are met.

441—99.22(252F) Mother's certified statement. Before initiating an action under Iowa Code chapter 252F, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child's caretaker. The unit shall obtain the Mother's Written Statement Alleging Paternity, Form 470-3293, from the child's mother certifying, in accordance with Iowa Code section 622.1, that the man named is or may be the child's biological father. Government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1 may also be used. In signing Form 470-3293, the mother acknowledges that the unit may initiate a paternity action against the alleged father, and she agrees to accept service of all notices and other documents related to that action by first-class mail. The mother shall sign and return Form 470-3293 to the unit within ten days of the date of the unit's request.
[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.23(252F) Notice of alleged paternity and support debt. Following receipt of the Mother's Written Statement Alleging Paternity, Form 470-3293, or government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1, the unit shall serve a notice of alleged paternity and support debt as provided in Iowa Code section 252F.3.
[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.24(252F) Conference to discuss paternity and support issues. The alleged father may request a conference as provided in Iowa Code section 252F.3, subsection (1), with the office that issued the notice to discuss paternity establishment and the amount of support he may be required to pay.

441—99.25(252F) Amount of support obligation. The unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

441—99.26(252F) Court hearing. If the alleged father requests a court hearing within the time frames specified in Iowa Code section 252F.3, or as extended by the unit, and paternity testing has not been conducted, the unit shall issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing.

441—99.27(252F) Paternity contested. The alleged father may contest the paternity establishment by submitting, within 20 calendar days after service of the notice upon him, as provided in rule 441—99.23(252F), a written statement contesting paternity to the address of the unit as set forth in the notice. The mother may contest paternity establishment by submitting, within 20 calendar days after the unit mailed her notice of the action or within 20 calendar days after the alleged father is served with the original notice, whichever is later, a written statement contesting paternity to the address of the unit as set forth in the notice. When paternity is contested, or at the unit's initiative, the unit shall issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing.

441—99.28(252F) Paternity test results challenge. Either party or the unit may challenge the results of the paternity test by filing a written notice with the district court within 20 calendar days after the unit issues or mails the paternity test results to the parties. When a party challenges the paternity test results, and requests an additional paternity test, the unit shall order an additional blood or genetic test, if the party requesting the additional test pays for the additional testing in advance. If the party challenges the first paternity test results, but does not request additional tests, the unit may order additional blood or genetic tests.

441—99.29(252F) Agreement to entry of paternity and support order. If the alleged father admits paternity and reaches agreement with the unit on the entry of an order for support, the father may acknowledge his consent on the Child Support Declaration, Form 470-4084. If the mother does not contest paternity within the allowed time period or if the mother waives the time period for contesting paternity, the unit may file the Child Support Declaration, if applicable, and Administrative Paternity Order with the court in accordance with Iowa Code section 252F.6.
[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.30(252F) Entry of order establishing paternity only. If the alleged father requests a court hearing on support issues and paternity is not contested, or if paternity was contested but neither party filed a timely challenge of the paternity test results, the unit shall prepare an order establishing paternity and reserving the support issues for determination by the court. The unit shall present the order and other documents supporting the entry of the ex parte paternity-only order to the court for review and approval prior to the hearing on the support issues.

441—99.31(252F) Exception to time limit. The unit may accept and respond to written requests for court hearings beyond the time limits allowed in this part.

441—99.32(252F) Genetic test costs assessed.

99.32(1) *Paternity established.* If genetic testing of an alleged father is conducted and that man is established as the child's father, the unit shall assess the costs of the genetic testing to the father who denied paternity and enter an order for repayment of these costs.

99.32(2) *Paternity not established.* If genetic testing of an alleged father is conducted and that man is not established as the child's father, the costs of the genetic testing shall not be assessed to any of the parties.

99.32(3) *Results contested.* If the results of the genetic testing are timely challenged and the challenging party requests additional testing, the party contesting the results shall advance the cost of the additional testing. If the challenging party does not advance payment for the additional testing, the unit shall certify the case to district court.

These rules are intended to implement Iowa Code chapter 252F.

441—99.33 to **99.35** Reserved.

PART C
PATERNITY DISESTABLISHMENT

441—99.36(598,600B) Definitions.

"Disestablishment" means paternity which is legally overcome under the conditions specified in Iowa Code section 600B.41A or section 598.21, subsection 4A.

"Nonrequesting parent" means a parent who is not filing a petition to overcome paternity.

"Requesting parent" means a parent who files a petition to overcome paternity.

441—99.37(598,600B) Communication between parents. When a parent who has filed a petition to disestablish paternity requests assistance from the child support recovery unit in contacting the other parent, the child support recovery unit shall take the following actions if services are being provided by the child support recovery unit, the location of the nonrequesting party is known, and the child support recovery unit has been provided a copy of the petition to disestablish paternity.

99.37(1) *Written contact.* The child support recovery unit shall send written notification to the nonrequesting parent of the requesting parent's desire to disestablish paternity and of the requesting parent's whereabouts. The notice shall state that the nonrequesting parent may cooperate in this action by filing a statement of the nonrequesting parent's current address or the name and address of the nonrequesting parent's attorney in the court file, or may contact the requesting parent with this information.

99.37(2) *Notification of requesting parent.* The child support recovery unit shall provide notification to the requesting party that contact was made with the nonrequesting party and that the nonrequesting parent may file a statement in the court file or may contact the requesting parent directly.

441—99.38(598,600B) Continuation of enforcement. The child support recovery unit shall continue all enforcement actions to collect current and accrued support as ordered until the unit receives a file-stamped copy of the order disestablishing paternity.

441—99.39(598,600B) Satisfaction of accrued support.

99.39(1) *Disestablishment orders entered before May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered before May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support assigned to the department.

a. The child support recovery unit shall satisfy only unpaid support assigned to the department and only if:

(1) For actions under Iowa Code section 600B.41A, blood or genetic testing was done and a guardian ad litem was appointed for the child.

(2) For actions under Iowa Code section 598.21, the written statement was filed and a guardian ad litem was appointed for the child.

b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.

c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(2) *Disestablishment orders entered on or after May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered on or after May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support:

a. If the order also contains a provision satisfying unpaid support, the unit shall adjust its records to show unpaid support is paid.

b. If the order does not contain a provision satisfying unpaid support, the unit shall satisfy only unpaid support assigned to the department. The unit shall notify the party who petitioned the court for disestablishment that this is the only support the unit can satisfy.

(1) The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver notice, the child support recovery unit is not prevented from satisfying amounts due the department.

(2) The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(3) *Termination of paternity.* If the court entered an order dismissing a disestablishment of paternity action on or before May 21, 1997, this subrule applies. Upon receipt of a file-stamped copy of an order terminating paternity under the requirements of Iowa Code section 600B.41A, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:

a. The child support recovery unit shall satisfy only unpaid support assigned to the department.

b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.

c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly terminated, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(4) *Previously collected moneys.* The child support recovery unit shall not return any moneys previously paid on the judgment.

These rules are intended to implement Iowa Code section 598.21, subsection 4A, and Iowa Code section 600B.41A.

441—99.40 Reserved.

DIVISION III
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT
[Prior to 9/1/93, see 441—95.11(252C)]

441—99.41(252C) Establishment of an administrative order.

99.41(1) *When order may be established.* The bureau chief may establish a child or medical support obligation against a responsible person through the administrative process. This does not preclude the child support recovery unit from pursuing the establishment of an ongoing support obligation through other available legal proceedings. When gathering information to establish a support order, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child's caretaker.

99.41(2) *Support debt.* When public assistance is paid to or Medicaid is received by a child of the responsible person, or the dependent child's caretaker, a support debt is created and owed to the department. When no public assistance is paid or Medicaid is received, the debt is owed to the individual caretaker.

99.41(3) *Notice to responsible person.* When the bureau chief establishes a support debt against a responsible person, a notice of child support debt shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26. The notice shall include all of the rights and responsibilities shown in Iowa Code section 252C.3. The notice shall also inform the responsible person which of these rights may be waived pursuant to Iowa Code section 252C.12, and the procedures for and effect of waiving these rights. The notice shall include a statement that failure to respond within the time limits given and to provide information and verification of financial circumstances shall result in the entry of a default judgment for support.

99.41(4) *Negotiation conference.* The responsible person may, within ten calendar days after being served the notice of child support debt, request a negotiation conference with the office of the child support recovery unit which sent the notice.

99.41(5) *Amount of support obligation.* The child support recovery unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

a. Any deviation from the guidelines shall require a written finding by the bureau chief.

b. Reserved.

99.41(6) Reserved.

99.41(7) *Court hearing.* Either the responsible person or the child support recovery unit may request a court hearing regarding the establishment of a support obligation through the administrative process.

a. The request for a hearing by the responsible person shall be in writing and sent to the office of the child support recovery unit which sent the original notice of the support debt by the latest of the following:

(1) Thirty days from the date of service of the first notice of support debt.

(2) Ten days from the date of the negotiation conference.

(3) Thirty days from the date the second notice and finding of financial responsibility is issued.

(4) Ten days from the date of issuance of the conference report if the bureau chief does not issue a second notice and finding of financial responsibility after a conference was requested.

b. When a request for a court hearing is received from the responsible person, within the time limits allowed, or is made by the child support recovery unit, the bureau chief shall schedule or request that the hearing be scheduled in the district court in the county:

(1) Where the dependent child resides if the child resides in Iowa.

(2) Where the responsible person resides if the child for whom support is sought resides in another state or the sole purpose of the administrative order is to secure a judgment for the time period that public assistance was expended by the state on behalf of the family or child.

99.41(8) *Exception to time limit.* The bureau chief may accept and respond to written requests for a court hearing beyond the time limits allowed in this rule.

99.41(9) *Entry of order.* If no request for a hearing is received from the responsible person at the local office of the child support recovery unit, or made by the unit, the bureau chief may prepare an order for support and have it presented ex parte to the court for approval.

a. The attorney for the child support recovery unit shall present the order and other documents supporting the entry of the ex parte order to the court for review and approval. Pursuant to Iowa Code chapter 252C, the court shall approve the order unless defects appear in the order or supporting documents.

b. The bureau chief shall file a copy of the approved order with the clerk of the district court.

c. The bureau chief shall send a copy of the filed order by regular mail, to the caretaker's last-known address, to the responsible person's last-known address or the caretaker's or the responsible person's attorney pursuant to the provisions of Iowa Code chapter 252C within 14 days after approval and issuance of the order by the court.

99.41(10) *Force and effect.* Once the order has been signed by the judge and filed, it shall have all the force and effect of an order or decree entered by the court. Unless otherwise specified, the effective date of the support obligation shall be the twentieth day following the date the order is prepared by the unit.

99.41(11) *Modification by bureau chief.* The bureau chief may petition an appropriate court for modification of a court order on the same grounds as a party to the court order can petition the court for modification.

This rule is intended to implement Iowa Code chapter 252C.

[**ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.42 to **99.60** Reserved.

DIVISION IV
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS
[Prior to 9/1/93, see 441—98.51(73GA,ch1244) to 98.60(73GA,ch1244)]

441—99.61(252B,252H) Definitions.

"Guidelines" means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

"Parent" means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

"Recipient of service" means a person receiving foster care services, or a recipient of family investment program assistance or Medicaid benefits whose child support or medical support is assigned, or a person who is not receiving public assistance but who is entitled to child support enforcement services pursuant to Iowa Code section 252B.4.

441—99.62(252B,252H) Review of permanent child support obligations. Permanent child support obligations that are ongoing and being enforced by the child support recovery unit or the child support agency of another state shall be reviewed by the unit to determine whether or not to adjust the obligation. The unit shall determine the appropriate obligation amount using the child support guidelines. Iowa must have continuing, exclusive jurisdiction to modify the order under Iowa Code chapter 252K.

99.62(1) *Periodic review.* A permanent child support obligation being enforced by the child support recovery unit and meeting the conditions in Iowa Code section 252H.12 may be reviewed upon the initiative of the unit if:

a. The right to any ongoing child support obligation is currently assigned to the state due to the receipt of public assistance.

b. The support order does not already contain medical support provisions.

c. A review is otherwise necessary to comply with state or federal law.

99.62(2) *Review by request.* A review shall be conducted upon the request of the child support recovery agency of another state or upon the written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. One review may be conducted every two

years when the review is being conducted at the request of either parent. The request for review may be no earlier than two years from the filing date of the support order or most recent modification or the last completed review, whichever is later.

99.62(3) *Review outcome.*

a. Procedures to adjust the support obligation shall be initiated only when the financial and other information available to the child support recovery unit indicates that the:

(1) Present child support obligation varies from the Iowa Supreme Court mandatory child support guidelines by more than 20 percent, and

(2) Variation is due to a change in financial circumstances which has lasted at least three months and can reasonably be expected to last for an additional three months.

b. Procedures to modify a support order may be initiated when the order does not include provisions for medical support.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.63(252B,252H) Notice requirements. The child support recovery unit shall provide written notification to each parent affected by a permanent child support obligation being enforced by the child support recovery unit as follows:

99.63(1) *Notice of right to request review.* The child support recovery unit shall notify each parent of the right to request review of the order and the appropriate place and manner in which the request should be made. Notification shall be provided on Form 470-0188, Application For Nonassistance Support Services, Form 470-1981, Notice of Continued Support Services, Form 470-3078, Availability of Review and Adjustment Services, or through another printed or electronic format.

99.63(2) *Notice of review.* One of the following shall apply:

a. At least 15 days before the review is conducted, the child support recovery unit shall serve notice of its intent to review the order on each parent affected by the child support obligation. This notice shall include a request that the parties complete a financial statement and provide verification of income. The notice shall be served in accordance with Iowa Code section 252B.26 or 252H.15.

b. If the conditions of Iowa Code section 252H.14A(1) are met, the unit may conduct a review using information accessible to the unit without:

(1) Issuing a notice under paragraph 99.63(2)*"a,"* or

(2) Requesting additional information from the parent.

99.63(3) *Notice of decision.* After the child support recovery unit completes the review of the child support obligation in accordance with rule 441—99.62(252B,252H), the unit shall issue a notice of decision in accordance with Iowa Code section 252H.14A or 252H.16 stating whether or not an adjustment is appropriate and, if so, the unit's intent to enter an administrative order for adjustment.

a. Rescinded IAB 2/5/03, effective 4/1/03.

b. Rescinded IAB 2/5/03, effective 4/1/03.

99.63(4) *Challenges to outcome of review.* Each parent shall be allowed to request a second review challenging the determination of the child support recovery unit. The procedure for challenging the determination is as follows:

a. The parent challenging the determination shall submit the request for a second review in writing to the child support recovery unit stating the reasons for the request and providing written evidence necessary to support the challenge. The request must be submitted:

(1) Within 10 days from the date of a notice of decision issued pursuant to Iowa Code section 252H.16, or

(2) Within 30 days from service of a notice of decision issued pursuant to Iowa Code section 252H.14A.

b. The child support recovery unit shall review the written evidence submitted with the request and all financial information available to the unit and make a determination of one of the following:

(1) Rescinded IAB 2/5/03, effective 4/1/03.

(2) To enter an administrative order for adjustment of the obligation.

(3) That adjustment of the child support obligation is inappropriate.

c. The unit shall send written notice of the outcome of the second review to each parent affected by the child support obligation at the parent's last-known mailing address.

d. For a review initiated under Iowa Code section 252H.15, if either parent disputes the second decision, the objecting parent may request a court hearing within 15 days from the date the notice of decision is issued or within 10 days of the date the second notice of decision is issued, whichever is later.

e. For a review initiated under Iowa Code section 252H.14A, either parent may request a court hearing within 10 days of the issuance of the second notice of decision.

f. If the unit receives a timely written request or the unit determines that a court hearing is necessary, the unit shall certify the matter to the district court. An objecting parent may seek recourse by filing a private petition for modification through the district court.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.64(252B,252H) Financial information. The child support recovery unit shall attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be reviewed necessary to conduct the review.

99.64(1) *Financial statements.* Except for a review initiated under Iowa Code section 252H.14A, both parents subject to the order to be reviewed shall provide a financial statement and verification of income within ten days of service of the notice of the unit's intent to review the obligation. If a review is initiated under Iowa Code section 252H.14A and the first notice of decision is challenged as described in subrule 99.63(4), both parents shall be requested to provide a financial statement and verification of income within ten days of the unit's request.

a. Verification of income shall include, but not be limited to, the following: copies of state and federal income tax returns, W-2 statements, pay stubs, or a signed statement from an employer or other source of income.

b. The child support recovery unit may also request that the parent requesting review provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

99.64(2) *Independent sources.* The child support recovery unit may utilize other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be reviewed.

a. These resources include, but are not limited to, the following: the Iowa workforce development department, the Iowa department of revenue, the Internal Revenue Service, the employment, revenue, and child support recovery agencies of other states, and the Social Security Administration.

b. In the absence of other verification of income and deductions allowed under the mandatory support guidelines, the child support recovery unit may estimate the net earned income of a parent for the purpose of determining the amount of support that would be due under the guidelines by deducting 20 percent from the gross earned income confirmed by an independent source. A parent may challenge this estimate by providing verification of actual earned income deductions.

99.64(3) *Availability of medical insurance.* Both parents subject to the order to be reviewed shall provide documentation regarding the availability of health insurance coverage for the children covered under the order, and the cost of the coverage, within ten days of a written request by the child support recovery unit. Verification may include, but not be limited to: a copy of the health benefit plan including the effective date of the plan, a letter from the employer detailing the availability of health insurance, or any other source that will serve to verify health insurance information and the cost of the coverage.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.65(252B,252H) Review and adjustment of a child support obligation.

99.65(1) *Conducting the review.* The child support recovery unit or its attorney shall review the case for administrative adjustment of a child support obligation unless it is determined that any of the following exist:

a. The location of one or both of the parents is unknown.

b. The variation from the Iowa Supreme Court mandatory child support guidelines is based on any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

c. The variation from the Iowa Supreme Court mandatory child support guidelines is due to a voluntary reduction in net monthly income attributable to the actions of the parent. The unit may request and the parent shall supply verification that a loss of employment was not voluntary or that all facts concerning financial information are true. Verification may include, but is not limited to, a statement from the employer, a doctor, or other person with knowledge of the situation.

d. The criteria of rule 441—99.62(252B,252H) are not met.

e. The end date of the order is less than 12 months in the future or the youngest child is 17½ years of age.

99.65(2) *Civil action.* The review and adjustment action that is certified to court for hearing shall proceed as an ordinary civil action in equity, and the child support recovery unit attorney shall represent the state of Iowa in those proceedings.

99.65(3) *Private counsel.* After the notice has been issued as described in subrule 99.63(2) or 99.63(3), any party may choose to be represented personally by private counsel. Any party who retains private counsel shall notify the child support recovery unit of this fact in writing.
[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.66(252B,252H) Medical support. The child support recovery unit, or its attorney, shall review the medical support provisions contained in any permanent child support order which is subject to review under rule 441—99.65(252B,252H) and shall include in any adjustment order a provision for medical support as defined in Iowa Code chapter 252E, and as set forth in 441—Chapter 98, Division I, or other appropriate provisions pertaining to medical support for all children affected directly by the child support order under review.
[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.67(252B,252H) Confidentiality of financial information. Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the review and adjustment process may be disclosed to the other parties to the case, or to the district court, as follows:

99.67(1) *Financial statements.* Statements of financial status may be disclosed to either party.

99.67(2) *Other documentation.* Supporting financial documentation such as state and federal income tax returns, pay stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court after the notice has been issued as described in subrule 99.63(2) or 99.63(3), unless otherwise prohibited by state or federal law.
[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.68(252B,252H) Payment of service fees and other court costs. Payment of fees for administrative review or service of process and other court costs associated with the review and adjustment process is the responsibility of the party requesting review unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of the division, "indigent" means that the requesting party's income is 200 percent or less than the poverty level for one person as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

441—99.69(252B,252H) Denying requests. A request for review by a parent subject to the order may be denied for the following reasons:

99.69(1) Rescinded IAB 8/2/95, effective 10/1/95.

99.69(2) It has been less than two years since the support order was filed with the court, last modified, or last reviewed for the purpose of adjustment.

99.69(3) The child support recovery unit or a child support agency of another state is not providing enforcement services for an ongoing support obligation under the order for which the review has been requested.

99.69(4) The request is based entirely on issues such as custody or visitation rights, which are not directly related to child support.

99.69(5) The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

99.69(6) The request is for the review of a temporary support order.

441—99.70(252B,252H) Withdrawing requests. If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall proceed as follows:

99.70(1) *Best interests of the child.* Rescinded IAB 2/5/03, effective 4/1/03.

99.70(2) *Consent of both parties.* The child support recovery unit shall notify the nonrequesting party of the requesting party's desire to withdraw the request.

a. If the nonrequesting party indicates a desire to continue the review, the unit shall proceed with the review and adjust the obligation, if appropriate.

b. If the nonrequestor indicates a desire to stop the process or fails to respond within ten days to the notification of the request to withdraw, the unit shall notify all parties that the review and adjustment process has been terminated.

99.70(3) *Effect of withdrawal.* If a request is successfully withdrawn pursuant to subrule 99.70(2), a later request by either party shall be subject to the limitations of subrule 99.62(2).

441—99.71(252H) Effective date of adjustment. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation amount shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the adjustment order with the court.

These rules are intended to implement Iowa Code sections 252B.5 to 252B.7 and 598.21C(2) and Iowa Code chapter 252H.

441—99.72 to **99.80** Reserved.

DIVISION V
ADMINISTRATIVE MODIFICATION

PREAMBLE

This division implements those provisions of Iowa Code chapter 252H which provide for administrative modification of support obligations when there is a substantial change in the financial circumstances of a party and when both parties agree to a change in an obligation through a cost-of-living alteration. These rules also provide for use of the administrative procedure to modify orders to add children, correct errors, set support which had previously been reserved or set at zero dollars, and increase support for minor obligors who do not comply with statutory educational or parenting class requirements or who are no longer minors.

441—99.81(252H) Definitions.

"Additional child" means a child to be added to an existing support order covering another child of the same parents.

"Born of a marriage" means a child was born of a woman who was married at the time of conception, birth, or at any time during the period between conception and birth of the child pursuant to Iowa Code chapter 252A and Iowa Code section 144.13.

"Cost-of-living alteration" means a change in an existing child support order that equals an amount which is the amount of the support obligation following application of the percentage change of the consumer price index for all urban consumers, United States city average, as published in the Federal Register by the federal Department of Labor, Bureau of Labor Statistics, pursuant to Iowa Code section 252H.2.

"Guidelines" means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

"Parent" means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

"Substantial change of circumstances," for the purposes of this division, means:

1. There has been a change of 50 percent or more in the net income of a parent, as determined by comparing the new net income with the net income upon which the current child support obligation was based, and
2. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months, pursuant to Iowa Code section 252H.18A.

441—99.82(252H) Availability of service. The child support recovery unit shall provide the services described in this division for a support order originally entered or a foreign order registered in the state of Iowa. The order must be one which:

1. Involves at least one child born of a marriage or one child for whom paternity has been legally established.
2. Is being enforced by the unit in accordance with Iowa Code chapter 252B.
3. Is subject to the jurisdiction of this state for the purposes of modification.
4. Is not subject to or is not appropriate for review and adjustment.
5. Provides for support of at least one child under the age of 18 or a child between the ages of 18 and 19 years who is engaged full-time in completing high school graduation or equivalency requirements in a manner which is reasonably expected to result in completion of the requirements prior to the person's reaching 19 years of age.
6. Has an obligation ending more than 12 months in the future.
7. Involves parents for whom the location of both parents is known.

441—99.83(252H) Modification of child support obligations. Permanent child support obligations meeting the criteria set forth in rule 441—99.82(252H) may be modified at the initiative of the unit, or upon written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. Any action shall be limited to adjustment, modification, or alteration of the child support or medical provisions of the support order. The duration of the underlying order shall not be modified. The procedures used by the child support recovery unit to determine if a modification is appropriate are as follows:

99.83(1) *Substantial change of circumstances.* Procedures to modify the support obligation may be initiated outside the minimum time frame described in subrule 99.62(2) if a request is received from either parent and if the parent has submitted verified documentation of a substantial change in circumstances which indicates both of the following:

a. A change of at least 50 percent in the net income of a parent as defined by guidelines. The new net income will be compared to the net income upon which the current child support obligation was based.

b. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months.

The unit shall review the request and documentation and, if appropriate, issue a notice of intent to modify as described in subrule 99.84(1).

99.83(2) *Adding provisions for additional children.* Procedures to modify the support obligation may be initiated if:

a. A parent requests, in writing, or the unit determines that it is appropriate to add an additional child to the support order and modify the obligation amount according to the guidelines pursuant to Iowa Code section 598.21B and Iowa Code section 252B.7A; and

b. Paternity has been legally established.

When adding a child to an order through administrative modification, medical support provisions shall apply to the additional child.

99.83(3) *Reserved, zero-dollar-amount, or medical-provisions-only orders.* Procedures to modify the support obligation may be initiated if:

a. A parent requests a modification in writing or the unit determines that it is appropriate to include a support amount based on the guidelines; and

b. The original order:

(1) Reserved establishment of an ongoing, dollar-amount support obligation giving a specific reason other than lack of personal jurisdiction over the obligor, or

(2) Set the amount at zero, or

(3) Was for medical provisions only.

99.83(4) *Corrections.* Procedures to modify the support obligation may be initiated if:

a. An error or omission pertaining to child support or medical provisions was made during preparation or filing of a support order; and

b. A necessary party requests a modification or the unit determines that a modification to correct an error or omission is appropriate.

99.83(5) *Noncompliance by minor obligors.* The unit may initiate procedures to modify a support order if a parent requests modification in writing or the unit determines that it is appropriate when:

a. An obligor who is under 18 years of age fails to comply with the requirement to attend parenting classes pursuant to Iowa Code section 598.21G; or

b. An obligor who is 19 years of age or younger fails to provide proof of compliance with education requirements described in Iowa Code section 598.21B(2)*"e"*; or

c. The obligor no longer meets the age requirements as defined in Iowa Code section 598.21B(2)*"e"* or 598.21G.

99.83(6) *Cost-of-living alteration.* A support order may be modified to provide a cost-of-living alteration if all the following criteria are met:

a. A parent requests a cost-of-living alteration in writing.

b. At least two years have passed since the order was filed with the court or last reviewed, modified, or altered.

c. The nonrequesting parent signs a statement agreeing to the cost-of-living alteration of the support order.

d. Each parent signs a waiver of personal service accepting service by regular mail.

e. The current support order addresses medical support for the children.

f. A copy of each affected order is provided, if the unit does not already have copies in its files.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11; **ARC 1357C**, IAB 3/5/14, effective 5/1/14]

441—99.84(252H) Notice requirements. The child support recovery unit shall provide written notification to parents affected by a permanent child support obligation being enforced by the unit as follows:

99.84(1) *Notice of intent to modify.* When a request for administrative modification is received or the unit initiates an administrative modification, the unit shall provide written notice to each parent of its intent to modify.

a. The notice shall include the legal basis and purpose for the action; a request for income or other information necessary for the application of guidelines (if applicable); an explanation of the legal rights and responsibilities of the affected parties, including time frames; and procedures for contesting the action.

b. The unit shall take the following actions to notify parents:

(1) Rescinded IAB 2/5/03, effective 4/1/03.

(2) If the modification is based on subrules 99.83(1) through 99.83(5), notice shall be provided to each parent. The notice shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26 or 252H.19.

(3) If the modification is based on provision of a cost-of-living alteration as established at subrule 99.83(6) and the required documentation is included, the child support recovery unit shall notify each parent of the amount of the cost-of-living alteration by regular mail to the last-known address of each parent or, if applicable, each parent's attorney. The notice shall include:

1. The method of determining the amount of the alteration pursuant to Iowa Code section 252H.21.
2. The procedure for contesting a cost-of-living alteration by making a request for review of a support order as provided in Iowa Code section 252H.24.
3. A statement that either parent may waive the 30-day notice waiting period. If both parents waive the notice waiting period, the unit may prepare an administrative order altering the support obligation.

99.84(2) *Notice of decision to modify.* The unit shall issue a notice of its decision to modify the support order to each parent affected by the support obligation at each parent's (or attorney's) last-known address. The notice shall contain information about whether the unit will continue or terminate the action and the procedures and time frames for contesting the action by requesting a court hearing pursuant to 441—subrule 99.86(2).

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.85(252H) Financial information. The child support recovery unit may attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be modified that is necessary to conduct an analysis and determine support. The unit does not require financial information if the request is for a cost-of-living alteration.

99.85(1) *Financial statements.* Parents subject to the order shall provide a financial statement and verification of income within ten days of a written request by the unit.

a. If the modification action is based on a substantial change of circumstances:

(1) The requesting party must provide Form 470-2749, Request to Modify a Child Support Order, and documentation that proves the amount of change in net income and the date the change took place, such as:

1. Copies of state and federal income tax returns, W-2 statements, or pay stubs, or
2. A signed statement from an employer or other source of income.

(2) The unit shall review the request and documentation. If appropriate, the unit shall issue to each parent a notice of intent to modify the order as stated in subrule 99.84(1) and a financial statement. Each parent shall complete and sign the financial statement and return it to the unit with verification of income and deductions as described in subrule 99.1(3).

b. The unit may require a completed and signed financial statement and verification of income from each parent as described in subrule 99.1(3) if the modification is based on:

(1) Addition of a child;
(2) Changing a reserved or zero-dollar-amount obligation;
(3) Changing a medical-provisions-only obligation;
(4) Making a correction (if financial information is needed); or
(5) Noncompliance by a minor obligor as defined in Iowa Code section 598.21B(2)*"e"* or 598.21G.

c. The unit may also request that a parent requesting a modification provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

d. The unit may also use the most recent wage rate information published by the department of workforce development or the median income for parents on the unit caseload to estimate the net earned income of a parent when a parent has failed to return a completed financial statement when requested and complete and accurate information is not readily available from other sources.

e. Self-employment income will be determined as described in subrule 99.1(5).

99.85(2) *Independent sources.* The child support recovery unit may use other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be modified as described in rule 441—99.1(234,252B).

99.85(3) *Guidelines calculations.*

a. The unit shall determine:

(1) The appropriate amount of the child support obligation (excluding cost-of-living alteration amounts) as described in rules 441—99.1(234,252B) through 441—99.5(234,252B), and

(2) Medical support provisions as described in Iowa Code chapter 252E and rules 441—98.1(252E) through 441—98.7(252E).

b. If the modification action is due to noncompliance by a minor obligor, as defined in Iowa Code section 598.21B(2)*"e"* or 598.21G, the unit will impute an income to the obligor equal to a 40-hour workweek at the state minimum wage unless the parent's education, experience, or actual earnings justify a higher income.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.86(252H) Challenges to the proposed modification action. For modification actions based on subrules 99.83(1) through 99.83(5), each parent shall have the right to request a conference to contest the proposed modification. Either parent, or the unit, may also request a court hearing. For requests made based on subrule 99.83(6), either parent may contest the cost-of-living alteration by making a request for a review and adjustment of the support order.

99.86(1) *Conference.* Either parent may contest the proposed modification based on subrules 99.83(1) through 99.83(5) by means of a conference with the office of the unit that issued the notice of intent to modify.

a. Only one conference shall be held per parent.

b. The request must be made within ten days of the date of service of the notice of intent to modify.

c. The office that issued the notice of intent to modify shall schedule a conference with the parent and advise the parent of the date, time, place, and procedural aspects of the conference.

d. Reasons for contesting the modification include, but are not limited to, mistake of fact regarding the identity of one of the parties or the amount or terms of the modification.

e. The child support recovery unit may conduct the conference in person or by telephone.

f. If the party who requested the conference fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

g. The results of a conference shall in no way affect the right of either party to request a court hearing pursuant to subrule 99.86(2).

h. Upon completion of the conference, the unit shall issue a notice of decision to modify as described in subrule 99.84(2).

99.86(2) *Court hearing.*

a. Either parent, or the unit, may contest the proposed modification, based on subrules 99.83(1) through 99.83(5), by requesting a court hearing within the latest of any of the following time periods:

(1) Twenty days from the date of successful service of the notice of intent to modify,

(2) Ten days from the date scheduled for a conference, or

(3) Ten days from the date of issuance of a notice of decision to modify.

b. If the unit receives a timely written request, the unit shall certify the matter to the district court as described in Iowa Code section 252H.8.

c. If a timely request is not received, if waiting periods have been waived, or if the notice periods have expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.9.

99.86(3) *Contesting a proposed cost-of-living alteration.* Either parent may contest a cost-of-living alteration within 30 days of the date of the notice of intent to modify by making a request for a review of the support order as provided in Iowa Code section 252H.13.

a. If the unit receives a timely written request for review, the unit shall terminate the cost-of-living alteration process and proceed with the review and adjustment process.

b. If a timely request is not made, or the notice waiting period has been waived by both parties, or the notice period has expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.24.

441—99.87(252H) Voluntary reduction of income.

99.87(1) The unit shall not modify the support order based on a substantial change of circumstances if a change in income is:

a. Due to a voluntary reduction in net monthly income attributable to the actions of the party, or

b. Due to any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

99.87(2) The unit may request verification that a loss of employment was not voluntary or that all facts concerning financial information are true. Verification may include, but is not limited to, a statement from the employer, a doctor, or other person with knowledge of the situation.

[**ARC 9352B**, IAB 2/9/11, effective 4/1/11]

441—99.88(252H) Effective date of modification. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the modification order with the court. If the modification is based on a reserved, zero-dollar-amount, or medical-provisions-only obligation, the new obligation shall be effective 20 days after generation of the administrative modification order.

441—99.89(252H) Confidentiality of financial information. Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the modification process may be disclosed to the other parties to the case, or the district court, as follows:

99.89(1) *Financial statements.* The financial statement or affidavit may be disclosed to either party.

99.89(2) *Other documentation.* Supporting financial documentation such as state and federal income tax returns, paycheck stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court unless otherwise prohibited by state or federal law.

441—99.90(252H) Payment of fees. Payment of service of process and other costs associated with the modification process is the responsibility of the party requesting modification unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of this division, "indigent" means that the requesting party's income is 200 percent or less than the poverty level for one person as defined by the United State Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

441—99.91(252H) Denying requests. A request for modification by a parent subject to the order may be denied if the criteria in rule 441—99.82(252H) are not met or the following conditions exist:

99.91(1) *Nonsupport issues.* The request is based entirely on issues such as custody or visitation rights.

99.91(2) *Request only for delinquent support.* The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

99.91(3) *Temporary order.* The request is for the modification of a temporary support order.

99.91(4) *Two-year time frame.* The request is for a cost-of-living alteration and it has been less than two years since the order was filed with the court or last reviewed, modified, or altered.

99.91(5) *Change of circumstances.* The request is based on a substantial change in circumstances and:

a. The requestor's net income has not changed by at least 50 percent, as required in paragraph 99.83(1)*"a,"* or

b. The requestor has not provided adequate documentation of the change in income, as required in subrule 99.85(1), or

c. The change in income has not yet lasted for three months, as required in paragraph 99.83(1)*"b,"* or

d. The change in income is not expected to last another three months, as required in paragraph 99.83(1)*"b,"* or

e. The change in income is a voluntary reduction attributable to the actions of the party, as explained in rule 441—99.87(252H), or

f. The change in income is due to material misrepresentation of fact, as explained in rule 441—99.87(252H).

441—99.92(252H) Withdrawing requests. If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall notify the nonrequesting party of the requesting party's desire to withdraw the modification request. If the nonrequesting party indicates, in writing, a desire to continue with the modification process, the child support recovery unit shall proceed, and if appropriate, modify the support order. If there is no response from the nonrequesting party or if the nonrequesting party also wants the process to end, the unit shall end the modification process. If the unit initiated the modification action, the unit may terminate the process if, after notifying both parents, neither parent indicates a desire to continue with the modification.

These rules are intended to implement Iowa Code chapter 252H.

441—99.93 to **99.100** Reserved.

DIVISION VI
SUSPENSION AND REINSTATEMENT OF SUPPORT

441—99.101(252B) Definitions. As used in this division, unless the context otherwise requires:

"Child" shall mean the same as defined in Iowa Code section 252E.1.

"Child support recovery unit" or *"unit"* shall mean the same as defined in rule 441—95.1(252B) and Iowa Code section 252B.1.

"Obligee" shall mean the same as defined in rule 441—98.1(73GA,ch1224).

"Obligor" shall mean the same as defined in rule 441—98.1(73GA,ch1224).

"Public assistance" shall mean the same as defined in Iowa Code section 252H.2.

"Spousal support" shall mean either a set amount of monetary support, or medical support as defined in Iowa Code section 252E.1, for the benefit of a spouse or former spouse, including alimony, maintenance, or any other term used to describe these obligations.

"Step change" shall mean a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

"Support" shall mean the same as defined in Iowa Code section 252D.16, and shall include spousal support and support for a child.

"Support for a child" shall mean either a set amount of monetary support (child support), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in this rule.

"Support order" shall mean the same as a "court order" as defined in Iowa Code section 252C.1.

441—99.102(252B) Availability of service. The child support recovery unit shall provide the services described in this division only with respect to support orders entered or registered in this state for which the unit is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

99.102(1) Services described in this division shall only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order under Iowa Code chapter 252K.

99.102(2) Services described in this division shall be provided only if no prior request for suspension of all or part of a support order has been filed with the unit during the two-year period preceding the request. However, if the request was filed during the two-year period preceding July 1, 2005, and the unit denied the request because the suspension did not apply to all children for whom support is ordered, the unit shall provide suspension services if the parents jointly file a request on or after July 1, 2005.

441—99.103(252B) Basis for suspension of support.

99.103(1) *Reconciliation.* The child support recovery unit shall assist an obligor and obligee in suspending support for a child and, if contained in a child support order, spousal support, when the obligor and obligee are reconciled and are residing together, with at least one child entitled to support under the order, in the same household.

99.103(2) *Change in residency.* The unit shall assist an obligor and obligee in suspending support for a child when the child is residing with the obligor; however, the unit shall not assist in suspending any spousal support provisions of a support order on this basis.

99.103(3) *Affected children.* The unit shall assist an obligor and obligee in suspending all or part of a support order as provided in this division if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, the unit shall assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, the unit shall assist in suspending the support obligations for children for whom the basis for suspension applies.

99.103(4) *Limited to current support.* The provisions in this division for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

99.103(5) *Duration of conditions.* The basis for suspension of support as provided in subrule 99.103(2) and subrule 99.103(3) must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by the child support recovery unit.

441—99.104(252B) Request for assistance to suspend.

99.104(1) *Submitting a request.* The obligor and obligee subject to a support order being enforced by the unit may request that the unit assist in having the ongoing support provisions suspended as follows:

a. A request for suspension shall be submitted to the local child support unit providing services using Form 470-3033, Request to Suspend Support, and Form 470-3032, Affidavit Regarding Suspension of Support.

b. The unit shall provide Forms 470-3032 and 470-3033 to the obligor or obligee upon request.

c. Both forms must be signed by both the obligor and the obligee affected by the order to be suspended. In the event that current support payments are assigned to an individual or entity other than the obligee named in the original order, but may revert to the original obligee at a future date without court action, both the original obligee and the current assignee must sign both forms.

d. Form 470-3032 must be notarized.

e. The request shall contain sufficient information to allow the local unit to identify the court order and parties involved, and a statement that the obligor and obligee expect the basis for suspension to continue for not less than six months.

f. If the obligor and obligee are requesting suspension of more than one order at the same time, the obligor and obligee shall be required to submit only one copy of Form 470-3033, identifying each order the request involves; however, the obligor and obligee shall be required to submit a separate, signed and notarized affidavit, Form 470-3032, for each order.

99.104(2) *Acknowledging requests.* The local unit providing services shall issue a written notice to the obligor and obligee indicating whether a properly completed request is accepted or denied.

a. This notice shall be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor's or obligee's attorney.

b. If the basis for suspension is reconciliation, one notice shall be sent to the address shared by the obligor and obligee. If the basis for suspension is a change in residency of the children entitled to support, a separate notice shall be issued to the obligor and obligee at their respective last known addresses.

c. A notice denying a request shall indicate the reason for denial.

99.104(3) *Denying requests.* A request for suspension shall be denied when:

a. The conditions specified in Iowa Code section 252B.20, rule 441—99.102(252B), or rule 441—99.103(252B) are not met.

b. and *c.* Rescinded IAB 12/7/05, effective 2/1/06.

d. Denial of a request is not subject to appeal or review under Iowa Code chapter 17A.

441—99.105(252B) Order suspending support. After approving a request to suspend support, the unit shall prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20.

99.105(1) When the basis for suspension is reconciliation, the suspension shall apply to any ongoing support provisions of the order, including medical support, with respect to any child residing with the parents and with respect to any spouse or former spouse entitled to support under the order to be suspended.

99.105(2) When the basis for suspension is a change in residency of one or more of the children entitled to support, the suspension shall apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor. Any spousal support also ordered in the same support order shall remain unaffected by this action.

99.105(3) A copy of the filed order shall be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor's or obligee's attorney.

441—99.106(252B) Suspension of enforcement of current support. The child support recovery unit shall suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. The unit shall continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

441—99.107(252B) Request for reinstatement. The unit may request that the court reinstate the suspended support obligation in accordance with the procedures found in Iowa Code section 252B.20.

99.107(1) Either the obligor or the obligee affected by the suspended order may request reinstatement by submitting a written request for reinstatement to the child support recovery unit. The request must indicate that reinstatement is being requested, the reason for reinstatement, and contain sufficient information to identify the court order and parties involved. The request must also be signed by the requesting party.

99.107(2) The unit may, at its own initiative, request that the court reinstate a support obligation when it is determined that a child for whom the obligation was suspended is receiving public assistance benefits.

99.107(3) The unit shall issue a written notice to any obligor or obligee requesting reinstatement, approving or denying the request. This notice shall be sent to the last known address of the requesting party by first-class regular mail and shall indicate any reason for denial.

99.107(4) A properly completed request for reinstatement shall be denied when any of the following conditions exist:

a. The request is made by someone other than the obligor, the obligee, or the obligor's or obligee's attorney.

b. Rescinded IAB 12/7/05, effective 2/1/06.

c. The unit is no longer providing enforcement services for the suspended order.

d. The request is received more than six months since the date of the filing of the order suspending support.

e. The request is for partial reinstatement of the suspended support order for some but not all of the children and the order does not contain a step change.

f. A court in this state would not have continuing, exclusive jurisdiction to reinstate the order under Iowa Code chapter 252K.

441—99.108(252B) Reinstatement. The child support recovery unit shall follow the procedures in Iowa Code section 252B.20, in seeking to have the court reinstate a support order.

99.108(1) The unit shall request that the court reinstate a spousal support provision previously suspended if the provision was included in the suspension in accordance with subrule 99.105(1) and if the unit receives a properly completed request from the obligor or the obligee.

99.108(2) The unit shall seek to have the previously suspended support for a child reinstated under this division when the conditions in paragraph *"a"* or *"b"* are met. This provision shall not prohibit any party, including the child support recovery unit, from taking other action to establish support as provided for by law.

a. The basis for suspension no longer applies to any of the children for whom support was suspended; or

b. The basis for suspension continues to apply to some but not all of the children for whom support was suspended, and there is a step change in the order.

441—99.109(252B) Reinstatement of enforcement of support. If a suspended support obligation is reinstated, the unit shall also reinstate all appropriate enforcement measures to enforce all reinstated ongoing support provisions of the support order.

441—99.110(252B) Temporary suspension becomes final. The temporary suspension of a support order under this division shall become final if not reinstated in accordance with Iowa Code section 252B.20.

These rules are intended to implement Iowa Code section 252B.20.

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CHAPTER 100
CHILD SUPPORT PARENTAL OBLIGATION PILOT PROJECTS

PREAMBLE

This chapter describes the parental obligation pilot projects participated in or developed by the department of human services child support recovery unit (CSRU). The purpose of these pilot projects is to develop new ways to assist parents in overcoming the barriers which interfere with their fulfilling their obligations to their children. For the purpose of these rules, parental obligations include emotional and personal involvement of the parents, beyond simply meeting their financial obligations. In order to encourage participation by parents, CSRU may offer various incentives for participation. These incentives may be offered through projects whose plans have been approved by the bureau chief or through projects in which CSRU participates and for which the bureau chief approves of CSRU's offering any or all of the incentives.

441—100.1(17A,80GA,HF667) Definitions.

"Assigned support arrearages" means support arrearages for which all rights have been and shall remain assigned to the state of Iowa.

"Bureau chief" means the chief of the bureau of collections of the department of human services or the bureau chief's designee.

"Child support recovery unit (CSRU)" means any person, unit, or other agency which is charged with responsibility for providing or assisting in the provision of child support enforcement services pursuant to Title IV-D of the Social Security Act.

"Director" means the director of the department of human services or designee.

"Funded pilot project" means any of the pilot projects funded in whole or in part by CSRU and approved by the bureau chief to assist parents in overcoming the barriers which interfere with their fulfilling obligations to their children. Each funded pilot project shall have a project plan approved by the bureau chief.

"Guidelines" means the mandatory child support guidelines established by the Iowa Supreme Court pursuant to Iowa Code section 598.21(4).

"Incentives" means, but is not limited to, establishment or modification of support obligations that deviate from guidelines and other encouragements to participate in pilot projects.

"Obligor" means a noncustodial parent or other natural person legally responsible for the support of a dependent.

"Participant" means a person who receives services or incentives through a pilot project.

"Periodic support payment" means the total support payment due in each time period in accordance with the established support obligation. If no current support is due, the periodic support payment is equivalent to the last current support amount as would be ordered under 441—Chapter 98, Division II.

"Project plan" means the written policies, procedures, eligibility criteria and other components, as described at subrule 100.3(2).

"Services" means, but is not limited to, mediation services, job skills training, neutral drop-off and pick-up sites, except as "services" is used in subparagraph 100.2(1)"a"(3), and does not include incentives.

"Unfunded pilot project" means any project in which CSRU participates which is funded totally by an entity or entities other than CSRU. The bureau chief may approve CSRU's participation in an unfunded pilot project in order to use the incentives offered through this chapter. Unfunded pilot projects are not required to submit a project plan, as described in subrule 100.3(2), for approval of the bureau chief.

441—100.2(17A,80GA,HF667) Incentives. CSRU may offer incentives to participants in funded and unfunded pilot projects to encourage their involvement in the projects. No obligation established or

modified under this rule may be less than the minimum amount allowed under guidelines. The available incentives include, but are not limited to, the following:

100.2(1) *Deviation from guidelines.*

a. CSRU may establish or modify a child support order which deviates from the guidelines amount when all of the following conditions exist:

(1) Both parents consent to the deviation.

(2) The child resides with either parent.

(3) Either parent is a participant receiving services from CSRU under Iowa Code chapter 252B and Title IV-D of the Social Security Act.

(4) The percentage of the deviation from the guideline amount of support does not change from any percentage of deviation that is currently ordered.

(5) Neither parent has previously withdrawn consent to a deviated order entered under this subrule.

b. The child support order may not deviate from the guidelines amount by more than 25 percent. This order is not effective until approved by and filed with the court.

100.2(2) *Modification of support obligations.* CSRU may modify a support obligation of a participant through the procedures described in 441—Chapter 99, Division IV, without regard to the two-year criteria as specified in 441—subrule 99.62(2).

a. Initial modifications. CSRU shall perform an initial, informal calculation of the support obligation for each participant. If the initial, informal calculation indicates that the present child support obligation is at least 10 percent higher than the Iowa Supreme Court mandatory child support guidelines, CSRU may proceed to modify the support order, upon application of the participant, through proceedings established by 441—Chapter 99, Division IV, or through any other procedure allowed by law, notwithstanding the provisions of 441—subrule 99.62(3). If beginning new employment, the obligor may waive the application of the rule requiring that the obligor's income has lasted for three months and will be expected to last an additional three months.

b. Subsequent modifications.

(1) Subsequent modifications may be initiated only by CSRU without regard to the requirement that the variance from the guidelines amount be more than 20 percent when any of the following occurs:

1. Both parents give consent to deviate from the guidelines as provided in subrule 100.2(1).
2. Either parent withdraws consent to deviate from guidelines in setting an obligation.
3. Participant involvement in the pilot project terminates.

(2) Subsequent modifications may also be initiated by CSRU when the participant's income changes.

c. This subrule does not limit the ability or right of a parent or caretaker or CSRU to file or request a modification under any other statute or available proceeding.

100.2(3) *Income withholding orders.* CSRU may direct an employer or other income provider to withhold no more than 25 percent of the nonexempt disposable income of the participant for a period of time not to exceed 12 consecutive months from the date of the direction to the first employer under this subrule.

100.2(4) *Satisfaction of the assigned support.*

a. A participant shall be granted a partial satisfaction of the support arrearages which are and which will remain owed by that participant to the state when that participant pays the entire amount of all that participant's periodic support payments. Satisfactions granted under this subrule shall apply only to those cases for which the entire periodic support payment is credited.

b. Each satisfaction shall be an amount equal to a percentage of that participant's support arrearages, which are and which will remain owed to the state, according to the following schedule:

(1) A one-time satisfaction of 15 percent of the amount when a participant pays the entire periodic support payment due in each of 6 consecutive calendar months.

(2) A one-time satisfaction of 35 percent of the amount when a participant pays the entire periodic support payment due in each of 12 consecutive calendar months.

(3) A one-time satisfaction of 80 percent of the amount when a participant pays the entire periodic support payment due in each of 24 consecutive calendar months.

c. A participant subject to an income withholding order shall be eligible for the satisfaction in this subrule if the sole reason for ineligibility is a disparity between the schedules of the participant's pay date and the scheduled date the payment is due.

d. A participant shall be eligible for a satisfaction under this subrule if the participant is no longer a participant, but has continued to pay the entire amount of that participant's periodic support payment without interruption.

441—100.3(17A,80GA,HF667) Application to be a funded pilot project. CSRU shall publish a request for project plans when it decides to initiate a pilot project and requests for grants exceed available funding. All applicants must be empowerment or decategorization groups.

100.3(1) *Contents of request for project plans.* The request for project plans shall contain the requirements for contents of the project plan, the stated goals of the project, the number of projects for which funding exists and any other parameter for the specific pilot project being advertised. The request shall also contain a deadline by which project plans must be submitted to the bureau chief.

100.3(2) *Contents of project plans.* Each funded pilot project shall have and maintain a project plan. At a minimum, the project plan shall contain or address the following:

a. Applicant's experience and success at establishing collaborations that include partners essential to the project.

b. The geographic area to be served and community need for projected services.

c. The population targeted to participate and the criteria to be used for the selection and termination of participants.

d. The means by which potential participants will be notified about project information including, but not limited to, the project services and incentives.

e. The types of services or incentives to be provided and the strategies directed to securing the emotional and financial support of children.

f. A clear statement of outcomes expected for project participants, benchmarks to indicate these outcomes are being attained and performance measures and reporting requirements.

g. The cost of the proposal, the significant level of community resources directed to the pilot, plans for continued funding after the end of the grant period and costs, if any, for project participants.

h. Strategies to increase public awareness of fatherhood issues.

i. Project duration, not to extend beyond October 1, 2006.

100.3(3) *Amendments to project plan.* Projects may submit proposed amendments to their project plan in writing to the bureau chief. The bureau chief shall have the option, after review, of approving or disapproving all proposed amendments to the project plan.

441—100.4(17A,80GA,HF667) Selection of projects.

100.4(1) *Funded pilot projects.* The bureau chief shall have sole authority to select funded pilot projects. The bureau chief shall also have sole authority to grant exceptions to allow participation by individuals outside the geographical area specified in the contents of project plan.

When funds are not available for all interested parties, the bureau chief shall select which of the project plans received on or before the deadline date shall be granted the status of funded pilot project. This selection of pilot projects shall be based upon the following criteria:

a. Demonstrated experience with establishing effective collaborations.

b. Geographic area selected and community need for the project.

c. Population to be targeted and criteria to be used to select and terminate participants.

d. Types of services and incentives to be offered and participant requirements to receive them.

e. Statement of project goals, outcomes for participants, benchmarks and performance measures.

f. Project monitoring and evaluation plan.

g. Public awareness campaign directed to community and potential participants.

h. Project budget and community financial participation.

100.4(2) *Unfunded pilot projects.* The bureau chief shall have sole authority to determine the extent of CSRU involvement in unfunded pilot projects based upon current needs and resources of CSRU.

Unfunded pilot projects shall submit periodic reports for the purpose of monitoring and evaluating the project.

441—100.5(17A,80GA,HF667) Termination of pilot projects. The bureau chief may immediately terminate CSRU's participation in a funded pilot project or an unfunded pilot project if:

1. The funded pilot project is not fulfilling the terms of its project plan or the unfunded pilot project is not fulfilling the terms for CSRU's participation in the pilot project; or
2. Funding is reduced, exhausted, eliminated or otherwise made unavailable.

441—100.6(17A,80GA,HF667) Reports and records.

100.6(1) *Reports.*

a. Funded pilot projects established under these rules shall report to CSRU at least quarterly, unless otherwise required by the project plan. The first report shall be due in the office of CSRU 30 days after the end of the first complete calendar quarter after the plan is approved. These reports shall include, but not be limited to, the following:

(1) Number of participants served.
(2) Services provided.
(3) Funds expended.
(4) Progress toward meeting individual participant outcomes.
(5) Progress toward meeting project outcomes.
(6) Progress toward meeting funding goals.
(7) Other information as specified in the project plan.

b. Unfunded pilot projects may vary from the requirements in paragraph *"a"* in their reporting and shall report as agreed upon by the project managers and the bureau chief.

100.6(2) *Records retention.* Funded and unfunded pilot projects established under these rules shall retain all records as necessary to meet the audit requirements of the sources of the project's funding.

441—100.7(17A,80GA,HF667) Appeals. Applicants dissatisfied with the grant selection decision of the bureau chief may file an appeal with the director. The letter of appeal must be received within ten working days of the date of the notice of decision and must include a request for the director to review the decision and the reasons for dissatisfaction. Within ten working days of the receipt of the appeal, the director shall review the appeal request and issue a final decision.

No disbursements shall be made to any applicant for a period of ten calendar days following the notice of decision. If an appeal is filed within the ten days, all disbursements shall be held pending a final decision on the appeal. All applicants involved shall be notified if an appeal is filed.

441—100.8(17A,80GA,HF667) Continued application of rules and sunset provisions. Except as provided in subrule 100.8(2), these rules shall terminate the earlier of October 1, 2006, or when legislative authority is discontinued.

100.8(1) *CSRU's participation in pilot projects.* If CSRU's participation has not terminated earlier, CSRU's participation in funded and unfunded pilot projects terminates at the same time as the termination of these rules.

100.8(2) *Receipt of incentives.* Participants receiving incentives under these rules may continue to receive the incentives after the termination of these rules or after they are no longer participants only as follows:

a. For subrule 100.2(1), deviation from guidelines. If service of process has been accomplished upon all parties before the earlier of termination of these rules or termination of participation, but an order disposing of the establishment or modification action has not been entered before that date, then the process may continue until entry of an order or other disposition.

b. For subrule 100.2(2), modification of support obligations. If service of process has been accomplished upon all parties before the earlier of termination of these rules or termination of

participation, but an order disposing of the modification action has not been entered before that date, then the process may continue until entry of an order or other disposition.

c. For subrule 100.2(2)"b"(1)"2," either parent withdraws consent to deviate from the guidelines. If a parent withdraws consent to deviate from the guidelines in setting an obligation, CSRU may initiate a subsequent modification as provided in 100.2(2)*"b"*(1)"2."

d. For subrule 100.2(2)"b"(1)"3," modification of support obligations. Any obligations set at an amount which deviates from the guidelines under this chapter shall continue only until the obligation is modified or reviewed under existing rules, at which time consent of the parents is not a sufficient basis for continuing the deviation.

e. For subrule 100.2(3), income withholding orders. This subrule shall apply to a participant or former participant for the full time period allowed in the subrule.

f. For subrule 100.2(4), satisfaction of the assigned support. This subrule shall apply to a participant or former participant for the full time period allowed in the subrule.

These rules are intended to implement 2003 Iowa Acts, House File 667, section 8, subsection 4b(3).

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TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA JUVENILE HOME

[Prior to 7/1/83, Social Services[770] Ch 101]
[Prior to 2/11/87, Human Services[498]]

441—101.1(218) Definitions.

"Assigned service worker" means the individual's social work case manager who is a department employee.

"Child" means a person under the age of 18 years.

"Contraband" means weapons, ammunition, tobacco, alcohol, drugs, money, altered authorized property, mood-altering plant material, obscene material as defined in Iowa Code section 728.1(5), explosives, material that can be used in the manufacture of explosives, or material advocating disruption of or injury to residents, employees, programs, or physical facilities. "Contraband" includes anything which is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Department" means the Iowa department of human services.

"Division administrator" means the administrator of the division of mental health and disability services within the department.

"Facility" means the Iowa juvenile home.

"Family" means spouse, child, parent, sibling, or grandparent.

"Gift or bequest" means anything of value that a facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written or oral complaint by or on behalf of an individual that involves:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Individual," as used in this chapter, means any child who is committed to the director of the department of human services and is admitted to and receives services from the Iowa juvenile home. The terms "student," "resident," "juvenile," and "youth" are synonymous with the term "individual."

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"Tobacco" means all forms of tobacco.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on one's self or another.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.2(218) Standards.

101.2(1) The Iowa juvenile home shall comply with:

a. Standards required for comprehensive residential facilities for children in 441—Chapter 115 except that requirements contained in 441—subrule 115.4(1) for staff ratios during prime programming time are waived when there is inadequate funding.

b. Standards related to mandatory reporting of child abuse found in rule 441—112.10(232).

101.2(2) The Iowa juvenile home shall comply with the standards for group living foster care facilities in 441—Chapter 114 except that:

a. Rules 441—114.6(237) on organization and administration and 441—114.9(237) on intake procedures do not apply.

b. Only sleeping rooms built after January 1, 1988, must meet the requirements in 441—paragraph 114.3(2)*"b."*

c. Staff job descriptions shall be identified by the department of administrative services' human resources enterprise.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.3(218) Admission.

101.3(1) *Population guidelines.* The facility population level shall be based on the population guidelines that the judicial branch, in consultation with the department, develops on the number of individuals who may be placed at a juvenile facility at any one time. Pursuant to those guidelines and the responsibility of the superintendent for admission of individuals, the superintendent and the chief juvenile court officers shall allocate to each judicial district the number of children from each district who may be placed in the facility for diagnosis and evaluation and for treatment.

101.3(2) *Acceptance of child.* A certified copy of the court order which complies with Iowa Code chapter 232 shall accompany the child to the facility, along with the relevant petitions.

a. A child shall be accepted for evaluation as specified in the court order only when a diagnostic bed is available.

b. A child shall be accepted into the regular program as specified in the court order only when a treatment bed is available.

c. A child adjudicated to have committed a delinquent act shall not be admitted to the Iowa juvenile home.

d. The superintendent or chief juvenile court officer shall notify the court when the appropriate space, service, or program is not available so that admission can be ordered when the facility can meet the child's needs.

101.3(3) *Time of admission.* When a child is to be admitted to the Iowa juvenile home, arrangements shall be made for the actual admission to occur between 8 a.m. and 4:30 p.m., Monday through Friday, whenever possible.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.4(218) Plan of care.

101.4(1) *Individual care plan conference.* At least ten working days before the individual care plan conference, the facility shall provide written notification of the time, date and nature of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. The court.

101.4(2) *Special meeting.* Whenever special concerns and needs arise regarding an individual, the superintendent or designee shall schedule a meeting to evaluate and formulate appropriate changes in the individual care plan. Notice of the meeting shall be issued to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. Other relevant parties.

101.4(3) *Prerelease conference.* A conference shall be held 30 days before any anticipated release of an individual from the regular program. At least 5 working days before the conference, the facility shall provide written notice of the time, date, and purpose of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. The court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.5(218) Communication with individuals.

101.5(1) *Incoming telephone calls.* Approval of the superintendent or designee is required for all incoming telephone calls for an individual before the conversation occurs. An authorized employee shall verify the identity of the caller before approval is given. Approved telephone calls shall not be monitored.

101.5(2) *Mail and packages.*

a. Outgoing or incoming letters and packages shall not be opened, read, censored, or tampered with in any manner except that, to search for and seize contraband, an employee may:

(1) Open, but not read, incoming and outgoing letters and packages in the presence of the individual to whom the letters and packages belong; or

(2) Require that the individual open the letters and packages in an employee's presence and disclose the contents.

b. Letters or packages found to contain contraband shall be confiscated. Both the sender and the intended receiver of the confiscated letters and packages shall be notified and given reasons for the action in writing within 48 hours of the action.

c. The superintendent or designee may terminate correspondence between an individual and another person when the individual's treatment team has determined that the correspondence is not in the individual's best interest and is detrimental to the individual's treatment plan. Termination shall be based on the circumstances of each case.

(1) The superintendent or designee shall provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

101.5(3) *Visits.*

a. *Schedule.* Visiting hours shall be from 10 a.m. to 4:30 p.m. on Saturday and Sunday. Visits by the individual's family or legal representative shall be encouraged. Necessary flexibility in these hours and days will be allowed.

(1) The superintendent may designate certain weekdays or holidays for visiting. The resident shall be responsible for informing visitors about designated visiting days.

(2) Visiting during times other than those described in this subrule shall require approval of the superintendent before the day of the visit.

b. *Applicability.* Other than a family member or legal representative, a person who wants to visit an individual shall obtain prior approval from the superintendent or designee before visiting. Visitation rights shall be denied to:

(1) A former juvenile home resident unless the former resident is a family member or has prior approval of the superintendent or designee;

(2) A parent whose parental rights have been terminated or limited by court order;

(3) A person who is restricted by court order from contact with the individual;

(4) A visitor who refuses to cooperate with the rules of the facility;

(5) A visitor who creates a disturbance or is hostile to the point of being disruptive;

(6) A visitor who passes or attempts to pass contraband to an individual or who aids in an escape or attempted escape;

(7) A visitor who is under the influence of or has been partaking of drugs or alcoholic beverages; and

(8) Any other person who, based on reasonable cause, is believed to pose a risk to the individual's treatment or to the safety or security of the facility.

c. Procedures.

(1) Visitors shall check in with security upon arrival. The employee on duty may request identification of the visitor. Failure to produce identification may result in denial of the visit.

(2) An individual shall be permitted to visit with up to six family members during any one visit. Family members under 18 years of age shall visit only with adult family supervision.

(3) An individual shall not be permitted to visit with the family of another individual unless the superintendent or designee has given prior approval. An individual shall have written authorization of the superintendent or designee before accompanying parents of another individual off grounds on a visit.

d. Limits. The superintendent reserves the right to limit or terminate visiting in all cases when doing so is in the best interests of the individual's personal and therapeutic needs. When limitation or termination of visiting rights occurs, the superintendent or designee shall:

(1) Immediately notify persons involved why the action was taken; and

(2) Place a written report in the individual's file.

101.5(4) *Attorney contacts.* An individual's attorney shall have the right to visit or have telephone contact with the individual at any reasonable time.

a. An individual shall have the right to contact the individual's attorney during normal business hours and at other times with prior approval of the attorney. Responsibility for payment for the cost of the contact shall be determined before the contact is made.

b. An individual who does not have an attorney shall be referred to the committing court for an attorney to be appointed.

101.5(5) *Interviews and statements.*

a. Request. Requests to interview an individual made by media (newspapers, television stations, radio stations, etc.), groups, or persons not related to the individual shall be made through the superintendent's office.

(1) The superintendent or designee shall inform the individual of the request and of the individual's right to agree to participate in the interview or to remain silent and not participate.

(2) If an interview may have an impact on the individual's legal status, the superintendent or designee shall contact the individual's attorney to determine if the attorney has any objection to the individual's participation.

b. Decision. When the individual agrees to participate, the interview shall be granted at the discretion of the superintendent. The superintendent may deny an interview in situations deemed detrimental to the individual. The person requesting the interview may appeal the superintendent's decision to the division administrator.

c. Procedure.

(1) Whenever an interview is granted, at least one facility employee shall be present for the entirety of the interview and shall have the authority to terminate the interview anytime the employee believes the best interests of the individual are not being served. Exceptions to this requirement shall be made when the individual's interview is with the individual's own attorney or with state officials acting in an official capacity.

(2) The individual shall be represented by legal counsel during any interview that is conducted to obtain information that will be or may be used in court.

d. Depositions. The superintendent may grant permission for written depositions according to the procedures for granting interviews. Voice recording of depositions shall not be permitted. One copy of the deposition shall be submitted to the superintendent. This rule shall in no way restrict depositions ordered by the court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.6(218) Photographing and recording of individuals. An individual's parent or legal representative may take photographs or make audio or video recordings of that individual but shall not be authorized to take photographs or make recordings of any other individual.

101.6(1) With the authorization of the superintendent or designee, an individual may take a photograph of another individual with that individual's consent.

101.6(2) Use of still or video cameras or voice recorders to photograph or record an individual by anyone other than the individual, parent, legal representative or authorized employee shall be allowed only with the prior authorization of the superintendent or designee.

a. When granted, authorization to photograph or record shall be for one specific use and shall not extend to any other use.

b. Photographs and video or voice recordings of an individual for public distribution shall be permitted only with a signed informed consent from the superintendent and the individual's parent or legal representative.

101.6(3) A person authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.7(218) Employment of individual. Employers that want to hire an individual must obtain approval from the superintendent or designee.

101.7(1) To clarify the employer-individual employment agreement, the superintendent or designee shall communicate to the individual's employer and document:

a. The employer's legal responsibilities, including:

(1) Adherence to child labor laws; and

(2) Payment in accordance with the Fair Labor Standards Act. Work of a more skilled nature shall be compensated accordingly.

b. The employer's responsibility to meet the requirements of the Iowa juvenile home, including but not limited to those relating to salary, supervision, transportation, and work hours of the individual. The employer shall:

(1) Make all payments for the individual's employment to the facility business office for deposit in the individual's account. Payment of any nature shall not be given directly to the individual for any purpose.

(2) Immediately report a runaway individual to the superintendent or designee.

(3) Report to the superintendent or designee an individual's behavior that is unacceptable to the employer.

101.7(2) An individual's behavior that is unacceptable to an employer shall not subject the individual to any sanctions, punishment or punitive restriction of privileges unless the behavior constitutes a public offense or violates facility rules. In such case, the individual may be referred to court for prosecution or the facility's discipline procedure may be followed.

101.7(3) The employer, the superintendent or designee, or the individual shall have the right to terminate the employment at any time.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.8(218) Temporary home visits.

101.8(1) An individual may be granted a temporary home visit for up to five days for reasons such as:

a. To attend funerals, weddings, or holiday functions;

b. For job seeking;

c. For the primary purpose of exploring and improving family and community relations; or

d. For a preplacement visit to a foster or group home to test the appropriateness of such a placement.

101.8(2) The superintendent or designee and the assigned service worker shall approve a temporary home visit before the visit is scheduled and only after the assigned service worker has investigated and approved in writing the temporary home visit placement.

101.8(3) Five working days in advance of a visit, the superintendent or designee shall notify the following in writing:

a. The individual's parents;

b. The individual's legal representative;

c. The temporary placement, if different from the parents' home;

d. The assigned service worker; and

e. The court.

101.8(4) In cases of an emergency, the notice required by subrule 101.8(3) may be delivered by telephone and shall be followed by a written notice explaining the special circumstance.

101.8(5) In a special case, based on the individual's treatment needs, the superintendent or designee may extend a temporary home visit when both the superintendent or designee and the assigned service worker's supervisor agree that the proposed extension is appropriate.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.9(218) Grievances. Any individual who believes the individual's rights have been violated by the Iowa juvenile home or who has a complaint concerning the individual's treatment at the Iowa juvenile home may file a grievance. The individual's parent, family, or legal representative may file a grievance on behalf of the individual by submitting the grievance in writing to the superintendent.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.10(218) Alleged child abuse. The department shall arrange for the investigation of any reported case of alleged child abuse. For cases in which the alleged perpetrator is a facility employee, contractor, or volunteer, or some other department employee, the investigation shall be conducted by an agency other than the department.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.11(233B) Cost of care. The Iowa juvenile home shall seek to recover a portion of the cost of care from an individual who has unearned income. In determining the amount to be recovered:

1. The individual shall be allowed to retain a personal allowance equal to the personal allowance amount established by the Social Security Administration for the Supplemental Security Income program.

2. The amount recovered shall not exceed the actual cost of care.

3. The cost of care shall be determined using the average per diem multiplied by the total days of care.

4. The superintendent may grant a one-time exception to recovery of up to $1,000 for a personal needs living expense if an individual is being discharged and has no viable means of support upon release.

This rule is intended to implement Iowa Code section 233B.16.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.12(218) Buildings and grounds.

101.12(1) *Tours.* Tours of the facility shall be subject to the prior approval of the superintendent or designee. Tours may be scheduled on weekdays from 8 a.m. to 4 p.m. by appointment through the superintendent's office. Approval shall be based on availability of employee time to conduct the tour and the programmatic and security needs of the facility.

101.12(2) *Public use.* Facility space shall be for the primary use of the Iowa juvenile home. All public use of facility space shall require prior approval of the superintendent or designee. Approval for

use shall be based on the order of requests received and on space availability after the programmatic and security needs of the facility are met.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.13(8,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the superintendent.

101.13(1) The superintendent or designee shall evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

101.13(2) The superintendent shall be responsible for accepting the gift or bequest and reporting it to the division administrator.

a. All monetary gifts or bequests shall be acknowledged in writing to the donor.

b. All gifts or bequests, regardless of value, shall be reported to the Iowa ethics and campaign disclosure board within 20 days of receipt of the gift or bequest using the board's Form-GB.

This rule is intended to implement Iowa Code sections 8.7 and 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

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CHAPTER 102
Reserved

CHAPTER 103
STATE TRAINING SCHOOL

[Prior to 7/1/83, Social Services[770] Ch 103]
[Prior to 2/11/87, Human Services[498]]

441—103.1(218) Definitions.

"Child" means a person under the age of 18 years.

"Contraband" means weapons, ammunition, tobacco, alcohol, drugs, money, altered authorized property, mood-altering plant material, obscene material as defined in Iowa Code section 728.1(5), explosives, material that can be used in the manufacture of explosives, or material advocating disruption of or injury to residents, employees, programs, or physical facilities. "Contraband" includes anything which is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Department" means the Iowa department of human services.

"Division administrator" means the administrator of the division of mental health and disability services within the department.

"Facility" means the state training school.

"Family" means spouse, child, parent, sibling, or grandparent.

"Gift or bequest" means anything of value that a facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written or oral complaint by or on behalf of an individual that involves:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Individual," as used in this chapter, means any child who is committed to the director of the department of human services and is admitted to and receives services from the state training school. The terms "student," "resident," "juvenile," and "youth" are synonymous with the term "individual." For purposes of the state training school, the term shall also include a person whose stay is extended beyond the age of 18 under the provisions of 2009 Iowa Code Supplement sections 232.53(2) and 232.53(4).

"Iowa sex offender registry" means a central registry of sex offenders established under 2009 Iowa Code Supplement chapter 692A that is maintained by the department of public safety.

"Juvenile court officer" means the same as defined in Iowa Code section 232.2(30).

"Juvenile offender" means a juvenile who is required to be registered with the Iowa sex offender registry and with the sheriff of the juvenile's county of residence.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Registration" means the submission of registration forms to the Iowa sex offender registry and to the sheriff of the person's county of residence.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"State training school" means the units for juvenile delinquents at the Eldora and Toledo facilities as defined in Iowa Code section 233A.1(2).

"Tobacco" means all forms of tobacco.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on one's self or another.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.2(218) Admission.

103.2(1) *Population guidelines.* The facility population level shall be based on the population guidelines that the judicial branch, in consultation with the department, develops on the number of individuals who may be placed at a juvenile facility at any one time. Pursuant to those guidelines and the responsibility of the superintendents for admission of individuals, the superintendents and the chief juvenile court officers shall allocate to each judicial district the number of children from each district who may be placed in the facility for diagnosis and evaluation and for treatment.

103.2(2) *Acceptance of child.* A certified copy of the court order which complies with Iowa Code chapter 232 shall accompany the child to the facility, along with the relevant petitions.

a. A child shall be accepted for evaluation as specified in the court order only when a diagnostic bed is available.

b. A child shall be accepted into the regular program as specified in the court order only when a treatment bed is available.

c. A child adjudicated as a child in need of assistance shall not be admitted to the state training school, except:

(1) For diagnosis and evaluation and then only when a current petition is on file that alleges the child to have committed a delinquent act, or

(2) When the child is also adjudicated delinquent and meets admission criteria for the state training school as a delinquent.

d. The superintendent or chief juvenile court officer shall notify the court when the appropriate space, service, or program is not available so that admission can be ordered when the facility can meet the child's needs.

103.2(3) *Time of admission.* When a child is to be admitted to the state training school, arrangements shall be made for the actual admission to occur between 8 a.m. and 4:30 p.m., Monday through Friday, whenever possible.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.3(218) Plan of care.

103.3(1) *Individual care plan conference.* At least ten working days before the individual care plan conference, the facility shall provide written notification of the time, date and nature of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. The court.

103.3(2) *Special meeting.* Whenever special concerns and needs arise regarding an individual, the superintendent or designee shall schedule a meeting to evaluate and formulate appropriate changes in the individual care plan. Notice of the meeting shall be issued to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. Other relevant parties.

103.3(3) *Prerelease conference.* A conference shall be held 30 days before any anticipated release of an individual from the regular program. At least 5 working days before the conference, the facility shall provide written notice of the time, date, and purpose of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. The court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.4(218) Communication with individuals.

103.4(1) *Incoming telephone calls.* Approval of the superintendent or designee is required for all incoming telephone calls for an individual before the conversation occurs. An authorized employee shall verify the identity of the caller before approval is given. Approved telephone calls shall not be monitored.

103.4(2) *Mail and packages.*

a. Outgoing or incoming letters and packages shall not be opened, read, censored, or tampered with in any manner except that, to search for and seize contraband, an employee may:

(1) Open, but not read, incoming and outgoing letters and packages in the presence of the individual to whom the letters and packages belong; or

(2) Require that the individual open the letters and packages in an employee's presence and disclose the contents.

b. Letters or packages found to contain contraband shall be confiscated. Both the sender and the intended receiver of the confiscated letters and packages shall be notified and given reasons for the action in writing within 48 hours of the action.

c. The superintendent or designee may terminate correspondence between an individual and another person when the individual's treatment team has determined that the correspondence is not in the individual's best interest and is detrimental to the individual's treatment plan. Termination shall be based on the circumstances of each case.

(1) The superintendent or designee shall provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

103.4(3) *Visits.*

a. *Schedule.* Visiting hours shall be from 10 a.m. to 4:30 p.m. on Saturday and Sunday. Visits by the individual's family or legal representative shall be encouraged. Necessary flexibility in these hours and days will be allowed.

(1) The superintendent may designate certain weekdays or holidays for visiting. The resident shall be responsible for informing visitors about designated visiting days.

(2) Visiting during times other than those described in this subrule shall require approval of the superintendent before the day of the visit.

b. *Applicability.* Other than a family member or legal representative, a person who wants to visit an individual shall obtain prior approval from the individual's juvenile court officer and the superintendent or designee before visiting. Visitation rights shall be denied to:

(1) A former training school resident unless the former resident is a family member or has prior approval of the superintendent or designee;

(2) A parent whose parental rights have been terminated or limited by court order;

(3) A person who is restricted by court order from contact with the individual;

(4) A visitor who refuses to cooperate with the rules of the facility;

(5) A visitor who creates a disturbance or is hostile to the point of being disruptive;

(6) A visitor who passes or attempts to pass contraband to an individual or who aids in an escape or attempted escape;

(7) A visitor who is under the influence of or has been partaking of drugs or alcoholic beverages; and

(8) Any other person who, based on reasonable cause, is believed to pose a risk to the individual's treatment or to the safety or security of the facility.

c. *Procedures.*

(1) Visitors shall check in with security upon arrival. The employee on duty may request identification of the visitor. Failure to produce identification may result in denial of the visit.

(2) An individual shall be permitted to visit with up to six family members during any one visit. Family members under 18 years of age shall visit only with adult family supervision.

(3) An individual shall not be permitted to visit with the family of another individual unless the individual's juvenile court officer and the superintendent or designee have given prior approval. An individual shall have written authorization of the individual's juvenile court officer and the superintendent or designee before accompanying parents of another individual off grounds on a visit.

d. Limits. The superintendent reserves the right to limit or terminate visiting in all cases when doing so is in the best interests of the individual's personal and therapeutic needs. When limitation or termination of visiting rights occurs, the superintendent or designee shall:

(1) Immediately notify persons involved why the action was taken; and

(2) Place a written report in the individual's file.

103.4(4) *Attorney contacts.* An individual's attorney shall have the right to visit or have telephone contact with the individual at any reasonable time.

a. An individual shall have the right to contact the individual's attorney during normal business hours and at other times with prior approval of the attorney. Responsibility for payment for the cost of the contact shall be determined before the contact is made.

b. An individual who does not have an attorney shall be referred to the committing court for an attorney to be appointed.

103.4(5) *Interviews and statements.*

a. Request. Requests to interview an individual made by media (newspapers, television stations, radio stations, etc.), groups, or persons not related to the individual shall be made through the superintendent's office.

(1) The superintendent or designee shall inform the individual of the request and of the individual's right to agree to participate in the interview or to remain silent and not participate.

(2) If an interview may have an impact on the individual's legal status, the superintendent or designee shall contact the individual's attorney to determine if the attorney has any objection to the individual's participation.

b. Decision. When the individual agrees to participate, the interview shall be granted at the discretion of the superintendent. The superintendent may deny an interview in situations deemed detrimental to the individual. The person requesting the interview may appeal the superintendent's decision to the division administrator.

c. Procedure.

(1) Whenever an interview is granted, at least one facility employee shall be present for the entirety of the interview and shall have the authority to terminate the interview anytime the employee believes the best interests of the individual are not being served. Exceptions to this requirement shall be made when the individual's interview is with the individual's own attorney or with state officials acting in an official capacity.

(2) The individual shall be represented by legal counsel during any interview that is conducted to obtain information that will be or may be used in court.

d. Depositions. The superintendent may grant permission for written depositions according to the procedures for granting interviews. Voice recording of depositions shall not be permitted. One copy of the deposition shall be submitted to the superintendent. This rule shall in no way restrict depositions ordered by the court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.5(218) Photographing and recording of individuals. An individual's parent or legal representative may take photographs or make audio or video recordings of that individual but shall not be authorized to take photographs or make recordings of any other individual.

103.5(1) With the authorization of the superintendent or designee, an individual may take a photograph of another individual with that individual's consent.

103.5(2) Use of still or video cameras or voice recorders to photograph or record an individual by anyone other than the individual, parent, legal representative, or authorized employee shall be allowed only with the prior authorization of the superintendent or designee.

a. When granted, authorization to photograph or record shall be for one specific use and shall not extend to any other use.

b. Photographs and voice or video recordings of an individual for public distribution shall be permitted only with a signed informed consent from the superintendent and the individual's parent or legal representative.

103.5(3) A person authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.6(218) Employment of individual. Employers that want to hire an individual must obtain approval from the superintendent or designee.

103.6(1) To clarify the employer-individual employment agreement, the superintendent or designee shall communicate to the individual's employer and document:

a. The employer's legal responsibilities, including:

(1) Adherence to child labor laws; and

(2) Payment in accordance with the Fair Labor Standards Act. Work of a more skilled nature shall be compensated accordingly.

b. The employer's responsibility to meet the requirements of the training school, including but not limited to those relating to salary, supervision, transportation, and work hours of the individual. The employer shall:

(1) Make all payments for the individual's employment to the facility business office for deposit in the individual's account. Payment of any nature shall not be given directly to the individual for any purpose.

(2) Immediately report a runaway individual to the superintendent or designee.

(3) Report to the superintendent or designee an individual's behavior that is unacceptable to the employer.

103.6(2) An individual's behavior that is unacceptable to an employer shall not subject the individual to any sanctions, punishment or punitive restriction of privileges unless the behavior constitutes a public offense or violates facility rules. In such case, the individual may be referred to court for prosecution or the facility's discipline procedure may be followed.

103.6(3) The employer, the superintendent or designee, or the individual shall have the right to terminate the employment at any time.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.7(218) Temporary home visits.

103.7(1) An individual may be granted a temporary home visit for up to five days for reasons such as:

a. To attend funerals, weddings, or holiday functions;

b. For job seeking;

c. For the primary purpose of exploring and improving family and community relations; or

d. For a preplacement visit to a foster or group home to test the appropriateness of such a placement.

103.7(2) The superintendent or designee and the individual's juvenile court officer shall approve a temporary home visit before the visit is scheduled and only after the juvenile court officer has investigated and approved in writing the temporary home visit placement.

103.7(3) Five working days in advance of a visit, the superintendent or designee shall notify the following in writing:

a. The individual's parents;
b. The individual's legal representative;
c. The temporary placement, if different from the parents' home;
d. The individual's juvenile court officer; and
e. The court.

103.7(4) In cases of an emergency, the notice required by subrule 103.7(3) may be delivered by telephone and shall be followed by a written notice explaining the special circumstance.

103.7(5) In a special case, based on the individual's treatment needs, the superintendent or designee may extend a temporary home visit when both the superintendent or designee and the individual's juvenile court officer agree that the proposed extension is appropriate.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.8(218) Grievances. Any individual who believes the individual's rights have been violated by the state training school or who has a complaint concerning the individual's treatment at the state training school may file a grievance. The individual's parent, family, or legal representative may file a grievance on behalf of the individual by submitting the grievance in writing to the superintendent.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.9(692A) Sex offender registration. An individual who has been determined to be a sex offender as defined in 2009 Iowa Code Supplement section 692A.101 must register as a sex offender before release from the state training school unless the juvenile court finds that the individual is exempted from this requirement.

103.9(1) *Notification.* When an individual who is a juvenile offender has not previously registered, the superintendent or designee shall provide the individual with Form DCI-144, Notification of Registration Requirement, as required by the department of public safety in 661—subrule 83.3(1). Failure to provide a juvenile offender with the notification form does not relieve the juvenile offender of the duty to register with the Iowa sex offender registry.

103.9(2) *Exemption from registration.* To exempt a juvenile offender from registration, the language in the order of adjudication or disposition must clearly state that the juvenile offender is exempted from the registration requirement. If a court order is silent, the registration requirement applies.

a. If the order language does not clearly state that the juvenile offender is exempted from the registration process, then the responsibility rests with the juvenile offender to seek a clarifying order to be exempt from the registration process. A juvenile offender who seeks an exemption from the registration requirement has the obligation to prove that the juvenile offender deserves the exemption.

b. When the judicial decision is deferred, registration shall be assumed to be required until the court orders otherwise. If the court order defers the decision to grant an exemption from registration until the juvenile offender's treatment is completed, the language in the order should specify who tracks the case until the new court order is issued. If it is not clear who tracks the case, the juvenile offender is responsible to seek a clarifying order to be exempt from the registration process.

103.9(3) *Registration.* The superintendent or designee shall provide the juvenile offender with Form DCI-145, Sex Offender Registration, as required by the department of public safety in 661—subrule 83.3(2). Form DCI-145 must be submitted to the sheriff of each county in which the offender will be residing, employed, or attending classes as well as to the department of public safety to satisfy the registration requirements of the Iowa sex offender registry.

a. When the juvenile offender is released from the state training school, the superintendent or designee shall submit the registration form to the division of criminal investigation of the department of public safety unless, by the time of release, the juvenile court finds that the juvenile should not be required to register as allowed by 2009 Iowa Code Supplement chapter 692A.

b. Copies of the sex offender registration shall be maintained in the juvenile offender's file at the state training school.

This rule is intended to implement 2009 Iowa Code Supplement section 692A.109.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.10(218) Alleged child abuse. The department shall arrange for the investigation of any reported case of alleged child abuse. For cases in which the alleged perpetrator is a facility employee, contractor, or volunteer, or some other department employee, the investigation shall be conducted by an agency other than the department.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.11(233A) Cost of care. The state training school shall seek to recover a portion of the cost of care from an individual who has unearned income. In determining the amount to be recovered:

1. The individual shall be allowed to retain a personal allowance equal to the personal allowance amount established by the Social Security Administration for the Supplemental Security Income program.
2. The amount recovered shall not exceed the actual cost of care.
3. The cost of care shall be determined using the average per diem multiplied by the total days of care.
4. The superintendent may grant a one-time exception to recovery of up to $1,000 for a personal needs living expense if an individual is being discharged and has no viable means of support upon release.

This rule is intended to implement Iowa Code section 233A.17.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.12(218) Buildings and grounds.

103.12(1) *Tours.* Tours of the facility shall be subject to the prior approval of the superintendent or designee. Tours may be scheduled on weekdays from 8 a.m. to 4 p.m. by appointment through the superintendent's office. Approval shall be based on availability of employee time to conduct the tour and the programmatic and security needs of the facility.

103.12(2) *Public use.* Facility space shall be for the primary use of the state training school. All public use of facility space shall require prior approval of the superintendent or designee. Approval for use shall be based on the order of requests received and on space availability after the programmatic and security needs of the facility are met.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.13(8,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the superintendent.

103.13(1) The superintendent or designee shall evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

103.13(2) The superintendent shall be responsible for accepting the gift or bequest and reporting it to the division administrator.

a. All monetary gifts or bequests shall be acknowledged in writing to the donor.

b. All gifts or bequests, regardless of value, shall be reported to the Iowa ethics and campaign disclosure board within 20 days of receipt of the gift or bequest using the board's Form-GB. One copy of the completed form shall be sent to the division administrator.

This rule is intended to implement Iowa Code sections 8.7 and 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

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CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105
JUVENILE DETENTION AND SHELTER CARE HOMES

[Prior to 7/1/83, Social Services[770] Ch 105]
[Prior to 2/11/87, Human Services[498]]

441—105.1(232) Definitions.

"Administer medication" means to remove medication from its storage place; to ensure to the extent possible that the child ingests, applies, or uses the appropriate dosage at the appropriate time of day; and to document the dosage and the time and date that the child ingested, applied, or used the medication.

"Authorized prescriber" means those persons identified in Iowa Code section 147.107 and Iowa Code chapter 154.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications as a component of a service plan for a particular child is not considered chemical restraint.

"Child care worker or house parent" shall mean an individual employed by a facility whose primary responsibility is the direct care of the children in the facility.

"Coed facility" shall mean a facility which has both sexes in residence.

"Control room" shall mean a locked room in a juvenile detention home, used for the purpose of isolation or seclusion of a child. A control room shall not be allowed in a juvenile shelter care home.

"Controlled substances" means those substances identified in Iowa Code chapter 124.

"County or multicounty" shall mean that the governing body is a county board of supervisors or a combination of representatives from county boards of supervisors.

"Facility" shall mean a county or multicounty "juvenile detention home" or county or multicounty "juvenile shelter care home" as those terms are defined in Iowa Code section 232.2.

"Family shelter home" means a family home providing temporary care for a child in a physically unrestricting home at any time between the child's initial contact with the juvenile authorities and the disposition of the case.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the hands, arms or legs.

"Nonprescription medication" means any drug or device that is not a prescription medication as defined in this chapter.

"Physical restraint" means direct physical contact required on the part of a staff person to prevent a child from hurting self, others, or property.

"Prescription medication" means a prescription drug as defined in Iowa Code section 155A.3(30).

"Prime programming time" is any period of the day when special attention or supervision is necessary, for example, upon awakening in the morning, during meals, later afternoon play, transitions between activities, evenings, and bedtime, weekends and holidays, in order to maintain continuity of programs and care. Prime programming time shall be defined by the facility and approved by the department of human services.

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—105.2(232) Buildings and grounds.

105.2(1) *Grounds.*

a. An outdoor play area of 75 square feet per child shall be provided.

b. The play area shall be identified and kept free from hazards that could cause injury to a child.

c. Rubbish and trash shall be kept separated from the play area.

d. The grounds shall be adequately drained.

105.2(2) *Buildings.*

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases, and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceilings surfaced with materials that are asbestos free.

b. All sleeping rooms shall be of finished construction and provide a minimum of 60 square feet per child for multiple occupancy, 80 square feet per child for single occupancy, and not sleep more than four children per room.

(1) Facilities licensed prior to July 1, 1981, having a square foot area less than that required shall be considered to meet these standards.

(2) There shall be not more than four youths per room in shelter and two youths per room in detention. Sleeping areas shall be assigned on the basis of the individual child's needs for privacy and independence of group support. For detention facilities built prior to July 1, 1979, four youths per room in detention may be allowed provided the minimum square feet per child requirement is met. When a detention facility licensed prior to July 1, 1979, remodels or makes an addition after July 1, 1979, only two youths per room shall be allowed.

c. All rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. All rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

105.2(3) *Bedrooms.*

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private belongings.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

105.2(4) *Heating.*

a. The heating unit shall be so located and operated as to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be properly vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas or oil heaters.

d. The heating and cooling plant shall be checked yearly and kept in a safe working condition at all times.

105.2(5) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given such items. Paper towels, when used, and toilet tissue shall be in dispensers. Detention facilities shall provide items required for personal hygiene but shall not be required to keep items in the bathrooms.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by a windowless door that completely fills the doorframe.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

105.2(6) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen food shall be kept at zero degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or less.

f. The kitchen and food storage areas shall be kept clean and neat. Food shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

105.2(7) *Personnel handling food.*

a. Shall be free of infection that might be transferred while preparing or handling food.

b. Shall be clean and neatly groomed.

c. Shall wear clean clothes.

d. Shall not use tobacco in any form while preparing or serving food.

105.2(8) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or less people at one meal.

b. Automatic or commercial dishwashers shall be used in facilities normally serving more than 15 people at one meal, as long as the following conditions are met:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain the wash water at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All hand-held food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns and similar equipment shall be cleaned and sanitized daily.

105.2(9) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform with all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food maintained at 45 degrees Fahrenheit or below.

105.2(10) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade "A."

105.2(11) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

105.2(12) *Private water supplies.*

a. Each privately operated water supply shall be annually checked and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples must be collected and submitted by the department of human services worker or local health sanitarian to the state hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria and nitrate (NO_3) content.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When no apparent deficiencies exist in the well and the water sample is approved, water safety requirements have been met.

e. When the water sample is not approved, the facility shall provide a written statement as to how the water supply will be upgraded.

f. A facility with unsafe water can meet water safety requirements by utilizing an alternative safe water source for children until the facility's own water supply is tested as safe. The facility must complete Form 470-0699, Provisions for Alternate Water Supply, and obtain approval from the department.

105.2(13) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

105.2(14) *Sewage treatment.*

a. Facilities shall be connected to public sewer systems where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

105.2(15) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly-tight, leakproof, and rodent proof and shall be maintained in a sanitary condition.

105.2(16) *General.*

a. Facilities shall take sufficient measures to ensure the safety of the children in care.

b. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

c. Radiators, registers and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

d. Fuse boxes shall be inaccessible to children.

e. Facilities shall have written procedures for the handling and storage of hazardous materials.

f. Firearms are prohibited in shelter care and detention facilities.

g. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

h. The facility shall have policies regarding fishing ponds, lakes or any bodies of water located on or near the institution grounds and accessible to the children.

105.2(17) *Emergency evacuation.* All living units utilized by children shall have a posted plan for evacuation in case of fire or disaster with practice drills held at least every six months.

105.2(18) *Fire inspection.* Each facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

105.2(19) *Local codes.* Each facility shall meet local building, zoning, sanitation and fire safety ordinances. Where no local standards exist, state standards shall be met.

441—105.3(232) Personnel policies.

105.3(1) *Policies in writing.* The following personnel policies and practices of the agency relating to a specific facility shall be described in writing and accessible to staff upon request:

a. Affirmative action and equal employment opportunity policies and procedures covering the hiring, assignment and promotion of employees.

b. Job descriptions for all positions.

c. Provisions for vacations, holidays and sick leave.

d. Effective, time-limited grievance procedures allowing the aggrieved party to bring the grievance to at least one level above that party's supervisor.

e. Authorized procedures, consistent with due process for the suspension and dismissal of an employee for just cause.

f. Written procedures for annual employee evaluation shall be in place for each facility and available to all staff upon request.

105.3(2) *Health of employees.* Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties. A statement attesting to these facts shall be secured at the time of employment and filed in the personnel records of the staff person. A new statement shall be secured at least every three years. The statement shall be signed by one of the following:

a. A physician as defined in Iowa Code section 135.1(4);

b. An advanced registered nurse practitioner who is registered with and certified by the Iowa board of nursing to practice nursing in an advanced role; or

c. A physician assistant licensed under Iowa Code chapter 148C.

105.3(3) *Personnel records.* A record shall be maintained by the facility as applicable for each volunteer who has direct responsibility for a child or access to a child when the child is alone and for each employee. The record shall contain at least the following:

a. Name, address, and social security number of the volunteer or employee.

b. A job application containing sufficient information to justify the initial and current employment.

c. Verification of education and experience. Applicants for positions having educational requirements shall be permanently employed only after the facility has obtained a certified copy of the transcript, diploma, or verification from the school or supervising agency. Applicants for positions having experience requirements shall be permanently employed only after the facility has obtained verification from the agency supervising the experience.

d. Verification of license. Applicants for positions requiring licenses shall be permanently employed only after the facility has obtained written verification of their licenses. Evidence of renewal of licenses as required by the licensing agency shall be maintained in the personnel record.

e. References. At least two written references or documentation of oral references shall be contained in the volunteer's or employee's personnel record. In case of unfavorable references, there shall be documentation of further checking to ensure that the person will be a reliable volunteer or employee.

f. A written, signed and dated statement which discloses any substantiated instances of child abuse, neglect or sexual abuse committed by the volunteer or job applicant.

g. Documentation of the submission of Form 470-0643, Request for Child Abuse Information, to the central abuse registry, the registry response, the department's evaluation of any abuse record discovered, and a copy of Form 470-2310, Record Check Evaluation, if the volunteer or staff person has completed and submitted it.

h. A written, signed and dated statement furnished by the new volunteer or applicant for employment which discloses any convictions of crimes involving the mistreatment or exploitation of a child.

i. Documentation of a check with the Iowa department of public safety on all new volunteers and applicants for employment using Form 595-1396, DHS Criminal History Record Check, Form B; a copy of the department's evaluation of any criminal record discovered; and a copy of Form 470-2310, Record Check Evaluation, if the volunteer or applicant has completed and submitted it.

j. Documentation of any checks with the Iowa department of public safety for persons hired before July 1, 1983, for whom the agency has reason to suspect a criminal record.

k. Current information relative to work performance evaluation.

l. Records of preemployment health examination or a record of a health report as required in 105.3(2) as well as a written record of subsequent health services rendered to an employee as necessary to ensure that all facility employees are physically able to perform their duties.

m. Information on written current reprimands or commendations.

n. Position in the agency, and date of employment.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 9829B**, IAB 11/2/11, effective 1/1/12]

441—105.4(232) Procedures manual. The facility shall have written policies and procedures specifying the manner in which the program of the facility is to be carried out.

441—105.5(232) Staff.

105.5(1) *Number of staff.*

a. *Generally.* A sufficient number of child care or house parent staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. Facilities having six or more residents shall have at least two staff persons on duty at all times that children are usually awake and present in the facility. Coed facilities having more than five residents should have both male and female staff on duty at all times. All child care or house parent staff shall be at least 18 years of age.

b. *On-call system.* There shall be an on-call system for coed facilities to provide that staff of the same sex as the resident shall perform the following:

(1) All personal body searches.

(2) Supervision of personal care.

c. *Prime programming time.* A minimum staff-child ratio of one child care worker or house parent to five children shall be maintained during prime programming times.

d. *Night hours.* At night, there shall be a staff person awake in each living unit and making regular visual checks throughout the night. The visual checks shall be made at least every hour in shelter care and every half hour in detention. A log shall be kept of all checks, including the time of the check and any significant observations. There shall be an on-call system which allows backup within minutes for both child care staff and casework personnel.

105.5(2) *Staff composition.* The composition of the program staff shall be determined by the facility, based on an assessment of the needs of the children being served, the facility's goals, the programs provided, and all applicable federal, state and local laws and regulations.

105.5(3) *Staff development.* Staff development shall be appropriate to the size and nature of the facility. There shall be a written plan for staff training that includes:

a. Orientation for all new employees, to acquaint them with the philosophy, organization, program practices, and goals of the facility.

b. Training of new employees in areas related to their job assignments.

c. Provisions in writing for all staff members to improve their competency through such means as:

(1) Attending staff meetings;

(2) Attending seminars, conferences, workshops, and institutes;

(3) Visiting other facilities;

(4) Access to consultants;

(5) Access to current literature, including books, monographs, and journals relevant to the facility's services.

d. There shall be an individual designated responsible for staff development and training, who will complete a written staff development plan which shall be updated annually.

105.5(4) *Organization and administration.* Whenever there is a change in the name of the facility, the address of the facility, the executive, or the capacity, the information shall be reported to the licensing manager. A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff. An executive director shall have full administrative responsibility for carrying out the policies, procedures and programs.

105.5(5) *Record checks.* The facility shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has been convicted of a crime involving the mistreatment or exploitation of a child. The facility shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone

if that person has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of volunteering or employment.

a. If a record of criminal conviction or founded child abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310, Record Check Evaluation.

b. In its evaluation, the department shall consider:

(1) The nature and seriousness of the crime or founded abuse in relation to the employment or volunteer position sought;

(2) The time elapsed since the commission of the crime or founded abuse;

(3) The circumstances under which the crime or founded abuse was committed;

(4) The degree of rehabilitation; and

(5) The number of crimes or founded abuses committed by the person involved.

[**ARC 9829B**, IAB 11/2/11, effective 1/1/12]

441—105.6(232) Intake procedures.

105.6(1) *Admissions.* Admission to shelter care or detention shall be in accordance with Iowa Code sections 232.20, 232.21 and 232.22. In no case shall a youth be admitted to detention or shelter care when the resulting admission would exceed the facility's approved client capacity. The facility and referring agency shall agree upon service responsibilities at the time of admission.

105.6(2) *Agency or court order placement.* Each agency or court placing a child in a facility shall make available to the facility the following:

a. A placement agreement should accompany the child.

When this is not possible, a copy of the placement agreement shall be provided the facility within 24 hours.

b. For court-ordered placements, a copy of the court order authorizing placement shall be provided to the facility within 48 hours.

c. When the child is in the facility more than four days, the following information shall be made available to the facility.

(1) All available psychological and psychiatric tests and reports concerning the child.

(2) Any available family social history.

(3) Any available school information.

105.6(3) *Self-referrals.* Any child admitting self to a facility shall be provided appropriate services. The facility shall notify the child's parents, guardian or the juvenile court as soon as possible concerning the child's admission to the facility but in any event the notification shall take place within 48 hours after the child's admission. Self-referrals shall not be accepted for placement in detention.

105.6(4) *Person responsible.* Each agency shall designate who has the authority to do intake. This may include anyone trained in intake procedures and who is designated to do intake.

105.6(5) *Intake sheet.* An intake sheet shall be completed on each child containing at least the information specified in 105.17(2).

441—105.7(232) Assessments.

105.7(1) *Personal.* At the time of intake and throughout a child's stay, individual needs will be identified by staff. The initial and ongoing determination of each child's needs will be based on written and verbal information from referral sources, observable behavior at intake, initial interview with the youth or family, school contacts, physical examination, and other relevant materials. The individual assessment shall provide the basis for development of a care plan for each youth.

105.7(2) *Educational.* An educational assessment shall be developed by the staff and referring worker for each child. When appropriate, other agencies such as the public schools and the area education agency shall be involved.

441—105.8(232) Program services.

105.8(1) *Care plan.* There shall be a written care plan developed for each resident remaining in the facility over four days. The care plan will be based on individual needs determined through the assessment of each youth. The care plan shall be developed in consultation with child care services, probation services, social services and educational, medical, psychiatric and psychological personnel as appropriate. The plan shall include:

a. Identification of specific needs;

b. Description of planned service;

c. Which staff person(s) will be responsible for each element of the plan;

d. Where services are to occur;

e. Frequency of activities or services.

105.8(2) *Educational programs.* All children currently enrolled in a school shall continue in that school when possible, or in an appropriate alternative. Where educational assessments indicate an educational need for a child not currently enrolled in public schools, an alternative shall be developed in cooperation with public schools, area education agency, and the referring worker. When an educational program is established within the facility it shall meet the educational and teaching standards established by the state department of public instruction. A child should be compelled to participate in an educational program only in compliance with the compulsory education law, Iowa Code chapter 299.

105.8(3) *Daily program.* The daily program shall be planned to provide a consistent, well structured, yet flexible framework for daily living, and shall be periodically reviewed and revised as the needs of the individual child or the living group change.

Attention shall be given to the special nature of the facility population and its resulting stresses, for example, rapid turnover in population and minimal screening at intake.

105.8(4) *Optional services.* When a facility provides services in addition to those required by these rules, they shall be clearly defined in writing.

105.8(5) *Recreation program.* The facility shall provide adequately designed and maintained indoor and outdoor activity areas, equipment, and equipment storage facilities appropriate for the age group which it serves. There shall be a variety of activity areas and equipment so that all children can be active participants in different types of individual and group sports and other motor activity.

a. Games, toys, equipment, and arts and crafts materials shall be selected according to age, number of children, and with consideration of the needs of children to engage in both active and quiet play. All materials shall be of a quality to ensure safety and shall be of a type which allows imaginative play and creativeness.

b. The facility shall plan and carry out efforts to establish and maintain workable relationships with the community recreational resources. The facility staff shall enlist the support of these resources to provide opportunities for children to participate in community recreational activities.

105.8(6) *Health care.*

a. *Health assessment at intake.* Facility staff shall review each child's health status at intake. The purpose of this preliminary review is to identify medication needs and problems that need immediate medical attention. Within seven days of intake, all reasonable efforts shall be made to perform a more comprehensive health assessment on each child who has not had a comprehensive health assessment within the past year. If the assessment cannot be performed within seven days, it shall be arranged for the earliest possible time, and the reasons for the delay shall be documented. A registered nurse, an advanced registered nurse practitioner, a physician assistant, or a physician shall perform the comprehensive health assessment.

b. *Existing health needs.* Facilities shall provide or secure medical treatment for a child's illnesses and injuries that come to the facility's attention during the child's stay.

c. *Monitoring side effects of medications.* Facilities shall monitor each child's use of medications and shall inform the authorized prescriber if adverse reactions are noted.

d. *Sharing medical information.* Facilities shall share information about significant changes in medical status with the child's caseworker and parents or guardian. Discharge information shall include information about significant medical changes that occurred while the child was at the facility.

105.8(7) *Counseling program.* Counseling services shall be related to the immediate problem, daily living skills, peer relationships, educational opportunities, vocational opportunities, future planning and preparation for placement, family counseling, and any other factors identified in the individual care plan. Counseling shall be done by appropriate staff personnel.

105.8(8) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the special food needs and tastes of children.

441—105.9(232) Medication management and administration.

105.9(1) *Obtaining prescription medications.* Facilities shall permit prescription medications to be brought into the facility for a child.

a. Prescription medication in its original container, clearly labeled and prescribed for the child, may be accepted as legitimate prescription medication for the child. The label serves as verification that the medication was ordered by an authorized prescriber.

b. Facilities shall review size, shape, color, and dosages and contact the identified pharmacy or authorized prescriber to confirm legitimacy if contraband is suspected.

105.9(2) *Obtaining nonprescription medications.* Shelter and detention facilities shall maintain a supply of standard nonprescription medications for use for children residing at the facility. Examples of standard nonprescription medications include cough drops and cough syrups, aspirin substitutes and other pain control medication, poison antidote, and diarrhea control medication.

a. All nonprescription medications kept on the premises for the use of residents shall be preapproved annually by a licensed pharmacist or an authorized prescriber.

b. Facilities shall maintain a list of all preapproved nonprescription medications. The list shall indicate standard uses, standard dosages, contraindications, side effects, and common drug interaction warnings. The facility administrator or the administrator's designee shall be responsible for determining the scope of the list and brands and types of medications included.

c. Only nonprescription medications on the preapproved list shall be available for use. However, the facility administrator or the administrator's designee, in consultation with an authorized prescriber or licensed pharmacist, may approve use of a nonprescription medication that is not on the preapproved list for a specific child.

105.9(3) *Storing medications.* Prescription and nonprescription medications shall be stored in a locked cabinet, a locked refrigerator, or a locked box within an unlocked refrigerator.

a. Controlled substances shall be stored in a locked box within a locked cabinet. Nothing other than controlled substances shall be stored in the locked box. Controlled substances requiring refrigeration also shall be maintained within a double-locked container separate from food and other items.

b. The facility administrator shall determine distribution and maintenance of keys to the medication storage cabinets and boxes.

c. A shelter facility administrator or the administrator's designee may preapprove shelter staff to carry prescription or nonprescription medications with them temporarily for use while on day trips or at sites away from the facility.

105.9(4) *Labeling medications.* Controlled substances and prescription medications shall be maintained in their original containers, clearly labeled by an authorized prescriber and prescribed for the child. Sample prescription medications shall be accompanied by a written prescription. Nonprescription medications shall be maintained as purchased in their original containers.

105.9(5) *Administering controlled medications.* Only staff who have completed a medication administration course shall be allowed to administer controlled substances.

105.9(6) *Administering prescription and nonprescription medications.* The facility administrator shall determine and provide written authority as to which staff may administer prescription and nonprescription medications.

a. Prescription medications shall be administered only in accordance with the orders of the authorized prescriber. Nonprescription medications shall be administered following the directions on the label.

b. The facility administrator or the administrator's designee may allow a child to self-administer prescription and nonprescription medication in appropriate situations. The facility shall require documentation if the child self-administers a medication.

105.9(7) *Documenting errors in administering medications.* All errors in administering prescription and nonprescription medications shall be documented. Facilities shall review and take appropriate action to ensure that similar errors do not recur.

105.9(8) *Medication for discharged residents.* When a child is discharged or leaves the facility, the facility shall turn over to a responsible agent controlled substances and prescription medications currently being administered. The facility may send nonprescription medications with the child as needed. The facility shall document in the child's file:

a. The name, strength, dosage form, and quantity of each medication.

b. The signature of the facility staff person turning over the medications to the responsible agent.

c. The signature of the responsible agent receiving the medications.

105.9(9) *Destroying outdated and unused medications.* Unused controlled and prescription medications kept at the facility for more than six months after the child has left the facility shall be destroyed by the administrator or the administrator's designee in the presence of at least one witness. Outdated, discontinued, or unusable nonprescription medications shall also be destroyed in a similar manner. The person destroying the medication shall document:

a. The child's name.

b. The name, strength, dosage form, and quantity of each medication.

c. The date the medication was destroyed.

d. The names and signatures of the witness and staff person who destroyed the medication.

441—105.10(232) Control room—juvenile detention home only.

105.10(1) *Written policies.* When a juvenile detention facility uses a control room as part of its service, the facility shall have written policies regarding its use and the facility director shall complete Form 470-0700, Evaluation and Recommendation to Operate a Control Room. The policy shall:

a. Specify the behaviors resulting in control room placement.

b. Delineate the staff members who may authorize its use as well as procedures for notification of supervisory personnel.

c. Document in writing behaviors leading to control room placement and the nature of the agreement reached with the child that will allow the child to return to the living unit.

105.10(2) *Physical requirements.* The control room shall be designed to ensure a physically safe environment that:

a. Has all switches controlling lights and ventilation outside of the room.

b. Allows for total observation of the child at all times.

c. Has protected recessed ceiling light.

d. Has no electrical outlets in the room.

e. Is properly heated, cooled and ventilated.

f. Has all doors, ceilings and walls constructed of strength and materials as to prevent damage to the extent that no harm could come to the child.

g. When a window is present, it is secured and protected in such a manner as to prevent harm to the child.

h. Is a minimum of 6 feet by 9 feet in size with at least a 7½ foot ceiling.

105.10(3) *Use.* A control room shall be used only when a less restrictive alternative to quiet or allow the child to gain control has failed. Utilization of the control room shall be in accordance with the following policies:

a. No more than one child shall be in the control room at any time.

b. There shall be provision for visual observation of the child at all times, regardless of the child's position in the room.

c. The control room should be checked thoroughly for safety and the absence of contraband prior to placing a child in the room.

d. The child shall be thoroughly checked before placement in the control room and all potentially injurious objects removed from such child including shoes, belts, pocket items, and similar items. The staff member placing the child in the control room shall document such check.

e. In no case shall all clothing or underwear be removed and the child shall be provided sufficient clothing to meet seasonal needs.

f. A staff member shall always be within hearing distance of the control room and the child shall be visually checked by the staff at least every 15 minutes and each check shall be recorded.

g. The child shall not remain in the control room longer than 1 hour except in consultation with and approval from the supervisor. Documentation in the child's case record shall include the time in the control room, the reasons for the control, and the reasons for the extension of time. Use of the control room for a total of more than 12 hours in any 24-hour period shall occur only in consultation with the referring agency or court. In no case shall a child be in a control room for a period longer than 24 hours.

h. The child's parents, referring worker, and the child's attorney shall be notified when the control room is used for more than a total of 30 minutes in any 24-hour period.

441—105.11(232) Clothing. All children shall have clothing that is suited to existing climate and seasonal conditions and is clean, dry and in good repair.

441—105.12(232) Staffings. The staff shall be available to participate in staffings or upon request to provide a written summary of the child's progress and behavior while in the facility program. Written recommendations regarding future planning and placement shall be provided to the referring agency or court upon request. Staff shall be available to discuss recommendations with the child's parent or guardian.

441—105.13(232) Child abuse. Written policies shall prohibit mistreatment, neglect or abuse of children and specify reporting and enforcement procedures for the facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Any employee for whom there is a substantiated instance of child abuse or failure to report child abuse shall be subject to the agency's policies concerning dismissal.

441—105.14(232) Daily log. The facility shall maintain a daily log. The log shall be used to note general progress in regard to the care plan and any problem areas or unusual behavior for each child.

441—105.15(232) Children's rights.

105.15(1) *Policies in writing.* All policies and procedures covered in this rule shall be in writing and provided to the child upon admission and made available to the child's parent or guardian upon request. If the child remains in care over four days, the policies and procedures shall be provided to the parent or guardian. The rationale and circumstances of any deviation from these policies shall be discussed with the child's parents or guardian and the referring worker, documented, and placed in the child's case record.

105.15(2) *Confidentiality.* Information regarding children and their families shall be kept confidential and released only with proper written authorization.

105.15(3) *Communication.*

a. Unless specifically regulated by the court, visitation shall be allowed with members of the child's immediate family.

b. Family visits shall be monitored only to the extent necessary to ensure the child's safety and facility security. Rationale for monitoring shall be documented in the child's record.

c. The child shall be permitted to communicate privately with legal counsel and the referring worker.

d. The child shall be allowed to conduct telephone conversations with family members. Telephone calls shall be monitored only to the extent necessary to ensure the child's well-being and facility security. Rationale for monitoring a child's conversation shall be documented in the child's record. Incoming calls may be screened by staff to verify the identity of the caller before approval is given.

e. The staff shall not open or read residents' mail. The child shall be allowed to send and receive mail. The facility may require the child to open incoming mail in the presence of a staff member when the mail is suspected to contain contraband articles, or to contain money that should be receipted and deposited.

f. When limitations on visitation or other communications are indicated, they shall be determined with the participation or knowledge of the child, family or guardian, and the referring worker. All restrictions shall have specific bases which shall be made explicit to the child and family and documented in the child's case record.

105.15(4) *Privacy.* Reasonable provisions shall be made for the privacy of residents.

441—105.16(232) Discipline.

105.16(1) *Generally.* A facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Discipline shall not include withholding of basic necessities such as food, clothing, or sleep. Agency staff shall be in control of and responsible for discipline at all times.

105.16(2) *Corporal punishment prohibited.* The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy shall be communicated in writing to all staff of the facility.

105.16(3) *Physical restraint.* The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

105.16(4) *Room confinement.* Facilities shall provide sufficient programming and staff coverage to enable children to be involved in group activities during the day and evening hours. A child shall only be confined to the child's room for illness, at the child's own request, or for disciplinary reasons. A juvenile detention home may confine a child to the child's room during normal sleeping hours if the facility has written policies and procedures which are approved by the department regarding this confinement.

105.16(5) *Written policies.* The facility shall provide to the child written policies specifying inappropriate behaviors, reasonable consequences for misconduct, and due process procedures available to the child. Upon request, the above information shall be provided to the child's parent or guardian and referring worker.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—105.17(232) Case files.

105.17(1) *Generally.* For the purpose of promoting a uniformity of program for all facilities and as an aid to the department of human services in determining its approval of a facility all facilities shall establish and maintain for inspection case files on each child.

105.17(2) *Face sheet.* For all children, a face sheet containing the following information shall be completed.

a. Full name, current address, and date of birth.

b. Parent's(s') full name(s).

c. Parent's(s') address and telephone number.

d. Religious preference of the child and also parent, if available.

e. Statement of who has legal custody and guardianship.

f. Name of referring worker and agency making the referral.

g. Telephone number and address of referring agency or court.

h. Name, address, and telephone number of the child's attorney.

105.17(3) *Written summary.* When a written summary has been requested under 441—105.12(232), a copy shall be placed in the child's record.

105.17(4) *Documentation.* The following information shall be documented in each child's record:

a. Appropriate notes on all significant contacts by staff with parents, referral person and other collateral contacts.

b. A summary related to discharge including name, address, and relationship of person to whom discharged.

105.17(5) *Other information.* The following information shall be requested when the child remains in the facility more than four days and, when available, placed in the child's record.

a. Current family history or social history.

b. Case plans submitted by the referring agency or orders of the court.

c. Psychological and psychiatric records; copies of all available testing performed plus notes and records of contact with the child.

d. Medical.

(1) A record of all illnesses, immunizations, communicable diseases and follow-up treatment.

(2) Medical and surgical authorization signed by the parent, guardian, custodian or court.

(3) A record of all medical and dental examinations including findings.

(4) Date of last physical examination prior to placement.

e. School.

(1) Name and address of school attended.

(2) Grade placement.

(3) Current school in which child is enrolled.

(4) Specific educational problems.

(5) Remedial action.

f. Placement agreement, court order, releases.

(1) Agreement shall authorize the facility to accept the child.

(2) The agreement shall set forth the terms of payment for care.

(3) Medical release authorizing emergency medical and surgical treatment, including the administration of anesthesia.

(4) All releases and authorizations shall be signed by the parent or legal guardian.

(5) All court orders affecting the custody or guardianship of the child.

441—105.18(232) Discharge.

105.18(1) Children in shelter care shall be discharged to a permanent placement at the earliest possible time, and in any event within 30 days from the date of admission. Extension requests shall be made, substantiated, and approved by both the referral agency and the shelter care agency by the twenty-fifth day of care. Maximum length of stay should not exceed 45 days. Maximum length of stay in detention should not exceed 21 days.

105.18(2) Rescinded IAB 3/31/04, effective 5/5/04.

441—105.19(232) Approval. The department will issue a Certificate of Approval, Form 470-0620, annually without cost to any juvenile detention home or juvenile shelter care home which meets the standards. The department may offer consultation to assist homes in meeting the standards.

105.19(1) *Applications.* An application shall be submitted on Form 470-0723, Application for License or Certificate of Approval. The application shall be signed by the operator of the home, chairman of the county board of supervisors, or chairman of the multicounty board of directors and shall indicate the type of home for which the application is made.

a. The withdrawal of an application shall be reported promptly to the department.

b. Each application will be evaluated by the department to ensure that all standards are met.

c. Reports and information shall be furnished to the department as requested.

105.19(2) *Rejection.*

a. Applications will be rejected when the minimum standards set forth in the rules in this chapter are not met.

b. Fraudulent applications will be rejected. A fraudulent application is one which contains false statements knowingly made by the applicant or one in which the applicant knowingly conceals information.

c. Applications will be rejected when the director of the facility has been convicted of a crime indicating an inability to operate a children's facility or care for children.

d. Applications will be rejected for just cause.

105.19(3) *Approval.* Approvals will be given for one year.

105.19(4) *Notification.* Homes should be notified of approval or rejection within 120 days of application unless the applicant requests and is granted an extension by the department. Form 470-0728, Notice of Action, will be used to inform applicants of approval, and a restricted certified letter will be used to inform applicants of rejection.

105.19(5) *Renewals.*

a. Applications for renewal shall be made on forms provided by the department and shall be made at least 30 days, but no more than 90 days, prior to expiration of the approval.

b. Each application for renewal will be evaluated by the department to ensure that standards continue to be met.

c. The application for renewal will be rejected or approved in the same manner as an application.

d. Decisions on renewals should be made within 60 days from the application for renewal. Notification of renewal decisions shall be the same as for new applications.

105.19(6) *Revocations.*

a. Approval shall be revoked by the state director for the following reasons:

(1) When the facility violates laws governing the provision of services or rules contained in this chapter.

(2) When the facility is misusing funds furnished by the department.

(3) When the facility is operating without due regard to the health, sanitation, hygiene, comfort, or well-being of the children in the facility.

(4) When the director has been convicted of a crime indicating an inability to operate a children's facility or care for children.

b. The following may be causes for revocation:

(1) Substantiated child abuse.

(2) When the facility staff has been convicted of a crime indicating an inability to operate a children's facility or care for children.

105.19(7) *Certificate of approval.* Upon approval, the home will be issued a certificate of approval containing the name of the home, address, capacity, and the date of expiration. Renewals will be shown by a seal bearing the new date of expiration, unless a change requires a new certificate to be issued.

441—105.20(232) Provisional approval.

105.20(1) *Required conditions.* A provisional approval may be issued at the time of application or reapplication for approval or as a result of a complaint investigation when all of the following conditions exist:

a. The shelter care or detention facility fails to meet the approval requirements.

b. A provisional approval has not previously been issued to the facility for the same deficiencies during the past year.

c. The deficiencies do not present an immediate danger to the child's physical or mental health.

d. The director of the facility, chairman of the county board of supervisors, or chairman of the multicounty board of directors provides the department with the following:

(1) A plan for correcting the deficiencies.

(2) The date by which the standards will be met.

If conditions *"b," "c,"* or *"d"* are not met, then the application for approval shall be rejected or the approval revoked.

105.20(2) *Time limited.* Provisional approvals shall not be issued for longer than one year.

105.20(3) *Completed corrective action.* When the corrective action is completed on or before the date specified on the provisional approval, a full approval shall be issued for the remainder of the year.

105.20(4) *Uncompleted corrective action.* When the corrective action is not completed by the date specified on a provisional approval, the department shall not grant a full approval and has the option of rejecting or extending the provisional approval. An extension of a provisional approval shall not cause the effective period of a provisional approval to exceed 18 months. If the corrective action plan is not completed within 18 months, the approval shall be rejected.

441—105.21(232) Mechanical restraint—juvenile detention only. When a juvenile detention facility uses mechanical restraints as part of its program, the facility shall have written policies regarding their use. These policies shall be approved by the department before use of mechanical restraints. The policies shall be available to clients, parents or guardians, and referral sources at the time of admission. Policies shall also be available to staff. The executive director of the detention home shall sign the commitment contained in Form 470-0703, Evaluation and Recommendation for Approval to Use Mechanical Restraint, before the facility shall be approved to use a mechanical restraint.

105.21(1) *Restrictions on mechanical restraints.*

a. Mechanical restraints shall not inflict physical injury.

b. Each use of mechanical restraint shall be authorized by the executive director of the facility, as discussed in 105.5(4), or other staff designated by the executive director if those staff meet one of the following requirements:

(1) Have a bachelor's degree in social work, psychology or a related behavioral science and one year of supervised experience in a juvenile shelter care, detention or foster group care facility.

(2) Have five years of supervised experience in a juvenile shelter care, detention or foster group care facility.

(3) Have some combination of advanced education in related behavioral sciences and supervised experience in a juvenile shelter care, detention or foster group care facility equal to five years. The facility shall have a written listing of all staff designated and qualified to authorize the use of mechanical restraint.

c. When immediate restraint is necessary to protect the safety of the child, other residents of the facility, staff or others, mechanical restraint may be utilized without prior authorization but in each case a person designated to provide authorization shall be contacted as soon as the child is restrained. The designated person shall visit the resident before determining if continued use of the mechanical restraint is necessary. If not viewed as necessary, the child shall be immediately released from restraint.

d. Each authorization of mechanical restraint shall not exceed one hour in duration without a visit by and written authorization from a licensed psychologist, psychiatrist or physician or psychologist employed by a local mental health center.

e. No child shall be kept in mechanical restraint for more than 1 hour in a 12-hour period without a visit by and written authorization from a licensed psychologist, psychiatrist or physician or psychologist employed by a local mental health center.

f. Anytime that a child is placed in mechanical restraint, a staff person shall be assigned to monitor the child with no duties other than to ensure that the child's physical needs are properly met. The staff person shall remain in continuous auditory and visual contact with the child.

g. Each child shall be released from mechanical restraint as soon as the restraints are no longer needed.

105.21(2) *Documentation.*

a. Each use of mechanical restraints shall be documented in the client's record and shall include at least the following:

(1) The date and time the child was placed in mechanical restraint.

(2) The type of mechanical restraint utilized.
(3) The reason for the restraint.
(4) The signature of the person authorizing the restraint and the time of authorization.
(5) The signature of the person placing the child in restraint.
(6) The signature of the person providing the continuous auditory and visual contact with the child.
(7) The signature of the person releasing the child and the time of release.

b. Each use of mechanical restraint shall be documented in a separate file which is used only for the recording of uses of mechanical restraints and shall contain the name of the child restrained and the information discussed in 105.21(2)*"a."*

c. Each facility authorized to use mechanical restraint shall submit a quarterly report to the bureau of adult, children and family services of the department which shall include all the information required in 105.21(2)*"b."*

105.21(3) *Continued use of mechanical restraints.* When a child requires mechanical restraint on more than four occasions during any 30-day period, the facility shall hold an immediate emergency meeting within 3 days of the fifth incident and shall have a licensed psychologist or psychiatrist or psychologist employed by a local mental health center present at the staffing to discuss the appropriateness of the child's continued placement at the facility.

105.21(4) *In transporting children.* Notwithstanding 105.21(1)*"d,"* mechanical restraint of a child by the staff of a juvenile detention facility while that child is being transported to a point outside the facility is permitted when there is a serious risk of the child exiting the vehicle while the vehicle is in motion. The facility shall place a written report on each use in the child's case record and the mechanical restraint file. This report shall document the necessity for the use of restraint.

Seat belts are not considered mechanical restraints. Agency policies should encourage the use of seat belts while transporting children.

441—105.22(232) Chemical restraint. Chemical restraint shall not be utilized in juvenile shelter care or detention facilities. Each juvenile shelter care or detention facility shall have written policies which clearly prohibit the use of chemical restraints.

These rules are intended to implement Iowa Code section 232.142 as amended by 2011 Iowa Acts, Senate File 482, section 7.

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CHAPTER 106
SAFETY STANDARDS FOR CHILDREN'S CENTERS

PREAMBLE

The intent of this chapter is to establish safety standards for facilities that meet the definition of "children's center" pursuant to Iowa Code chapter 237B. Chapter 237B requires the department to establish standards but does not delegate regulatory or enforcement authority to the department or any other state agency. Thus, these rules do not establish a certification or licensure process or provide for enforcement.

Iowa Code chapter 237B specifies that the standards established shall be broad facility standards for the protection of children's safety and not program standards or other requirements involving program development or oversight of the programs provided to the children served by children's centers. These rules cover definitions; application of the standards; provision of basic needs; protection from mistreatment, physical abuse, sexual abuse, and neglect; record checks; seclusion and restraints; health; safety; emergencies; and buildings.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.1(237B) Definitions.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications is not considered chemical restraint.

"Child" means a person who is less than 18 years of age.

"Children's center" means a privately funded facility that is designed to serve seven or more children at any one time who are not under the custody or authority of the department of human services, juvenile court, or another governmental agency and that offers one or more of the following services:

1. Child care.
2. Child care for children with a chronic illness.
3. Respite care.
4. Family support services.
5. Medical equipment.
6. Therapeutic day programming.
7. Educational enrichment.
8. Housing.

"Control room" means a locked room used for treatment purposes.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the child's hands, arms, or legs.

"Physical restraint" means direct physical contact required on the part of a staff member, volunteer, or others who perform duties under a subcontract with the children's center to prevent a child from hurting self, others, or property.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.2(237B) Application of the standards. These rules shall apply to all facilities that meet the definition of "children's center" pursuant to Iowa Code chapter 237B. In the event that a children's center is also subject to licensure, certification, registration, or regulation pursuant to another provision of law, those legal requirements shall take precedence over these rules.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.3(237B) Providing for basic needs.

106.3(1) A children's center shall provide the following for children in its care:

a. Adequate shelter;

b. Nourishing food and water; and

c. Opportunities for adequate sleep, exercise, cleanliness, and health maintenance.

106.3(2) A children's center shares responsibility for meeting these needs with the children's parents, guardians, or other primary caretakers, depending upon the amount of time the child spends in the children's center each day.
[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.4(237B) Protection from mistreatment, physical abuse, sexual abuse, and neglect. The state of Iowa prohibits child abuse as defined in Iowa Code chapter 232, criminal assault, and other criminal acts of violence. A children's center shall not use discipline that amounts to child abuse or a criminal act of violence.

106.4(1) A children's center shall have written policies that:

a. Prohibit mistreatment, physical abuse, sexual abuse, and neglect of children;

b. Define types of discipline and the reasons discipline would be used; and

c. Specify reporting and enforcement procedures for the children's center.

106.4(2) Discipline policies shall be discussed with:

a. Staff, volunteers, or others who perform duties under a subcontract with the children's center; and

b. Parents or guardians before children are admitted to the children's center.

106.4(3) A children's center shall not employ or use as a volunteer or subcontractor any person who poses any threat to the children in the center's care.

106.4(4) A children's center shall have written policies related to:

a. Children's communication with their parents, guardians, and other outside authorities.

b. Children's ability to receive visitors who have been approved by their parents or guardians.

c. Confidentiality and reasonable privacy for children. The children's center shall afford children and their families privacy and confidentiality unless doing so would jeopardize a child's health or safety.

d. Children's ability to keep personal belongings that connect the children to their families and community, such as clothing, pictures, and other items.

e. Children's ability to participate in normal community activities that have been approved by their parents or guardians.

106.4(5) A children's center shall not impose unreasonable rules and restrictions that prevent communication and connections with parents, guardians, other family members, or authorities.

106.4(6) A children's center shall share its written policies related to communication, visitors, personal belongings, and participation in community activities with a child's parents or guardians before a child is admitted to the children's center.
[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.5(237B) Record checks.

106.5(1) A children's center shall conduct record checks for:

a. Any owner, director, staff member, volunteer, or other person who performs duties under a subcontract with the children's center and who:

(1) Has direct responsibility for children, or

(2) Has access to a child when the child is alone.

b. Anyone living in the children's center who is 14 years of age or older.

106.5(2) The record checks shall be conducted to determine whether the person:

a. Has any founded child abuse reports;

b. Has any founded dependent adult abuse reports;

c. Has any criminal convictions; or

d. Has been placed on the sex offender registry.

106.5(3) Every applicant for employment shall submit to the children's center a written, signed and dated statement that discloses:

a. Any substantiated instances of child abuse, neglect, or sexual abuse committed by the person;

b. Any substantiated instances of dependent adult abuse committed by the person; and

c. Any convictions of crimes involving the mistreatment or exploitation of a child.

106.5(4) A children's center may request additional information from the central abuse registry or the Iowa department of public safety.

106.5(5) If a record of criminal conviction or founded child abuse or founded dependent adult abuse exists, the children's center shall evaluate the crime or founded child abuse or dependent adult abuse to determine whether or not the crime or founded child abuse or founded dependent adult abuse merits prohibition of employment or any voluntary or subcontracted position. The evaluation shall consider:

a. The nature and seriousness of the crime or founded abuse in relation to the position sought,

b. The time elapsed since the commission of the crime or founded abuse,

c. The circumstances under which the crime or founded abuse was committed,

d. The degree of rehabilitation,

e. The number of crimes or founded abuses committed by the person involved, and

f. The likelihood that the person will commit the crime or founded abuse again.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.6(237B) Seclusion and restraints.

106.6(1) A children's center shall not physically restrain a child unless it is necessary to prevent the child from hurting self, others, or property. Physical restraint must be conducted in a standing position whenever possible. Prone restraint is prohibited.

106.6(2) A children's center shall not put a child into time-out seclusion for more than one hour. A child shall never be secluded in an area that is locked or out of the view of staff, volunteers, or others who perform duties under a subcontract with the children's center.

106.6(3) At no time shall a children's center use a control room, mechanical restraint, or chemical restraint.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.7(237B) Health.

106.7(1) A children's center shall obtain, store, prepare, and serve food and water free from contamination.

106.7(2) A children's center shall have written health policies that include criteria for excluding a sick child from the center.

106.7(3) A children's center shall have written policies and procedures related to disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. A children's center shall take precautions to prevent the spread of infectious and communicable disease.

106.7(4) A children's center shall seek immediate medical attention for a child when it is necessary to ensure that the child remains healthy.

106.7(5) A children's center shall have written policies and procedures to ensure that staff, volunteers, or others who perform duties under a subcontract with the children's center demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease.

106.7(6) A children's center shall be required to report to the department of public health any reportable disease.

106.7(7) A children's center shall have written policies on physical examination reports or health status statements for all children in the center's care.

106.7(8) A children's center shall have written policies and procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications.

106.7(9) A children's center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff, volunteers, or others who perform duties under a subcontract with the children's center at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

106.7(10) A children's center shall have written policies on reporting illness or injury to parents or guardians. These policies shall be shared with parents or guardians before a child is admitted to the

children's center. Incidents resulting in a serious injury to a child or significant change in health status shall be reported immediately to the parent or guardian.

106.7(11) A children's center shall have written policies on smoking and tobacco use that comply with Iowa state law.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.8(237B) Safety.

106.8(1) A children's center shall maintain a staff-to-child ratio and follow safe practices that are based on the ages and needs of the children in care to ensure adequate supervision and child safety.

106.8(2) Poison control centers' telephone numbers shall be posted in prominent locations and readily available. All poisonous or caustic drugs or materials shall:

a. Be plainly labeled;

b. Be stored separately from other drugs in a specific, well-illuminated cabinet, closet, or storeroom;

c. Be stored in a manner that prevents accidental or intentional ingestion; and

d. Be accessible only to authorized persons.

106.8(3) A children's center shall have written policies regarding fishing ponds, lakes, or any bodies of water located on or near the center's grounds and accessible to children.

a. All swimming pools shall conform to state and local health and safety regulations.

b. Adult supervision shall be provided at all times when children are near or in the water.

106.8(4) A children's center shall have written policies regarding transportation of a child that ensure compliance with Iowa Code section 321.446 regarding child restraint devices.

a. Drivers of vehicles shall possess a valid driver's license.

b. Drivers shall not operate a vehicle while under the influence of alcohol, illegal drugs, or prescription or nonprescription drugs that could impair their ability to operate a motor vehicle.

c. All vehicles used for children's center activities shall be maintained in safe operating condition.

d. A children's center shall have proof of current insurance that covers all vehicles and drivers used to transport children.

106.8(5) Animals kept on site shall:

a. Be in good health with no evidence of disease,

b. Be of such disposition as to not pose a safety threat to any person, and

c. Be maintained in a clean and sanitary manner.

106.8(6) Offensive or dangerous weapons and ammunition shall be kept under lock and key and inaccessible to children. When these weapons are used, a children's center shall have written policies regarding their purpose, use, and storage.

[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.9(237B) Emergencies.

106.9(1) A children's center shall have written emergency plans for responding to evacuations, fires, tornadoes, floods, blizzards, other weather incidents, power failures, bomb threats, chemical spills, earthquakes, or other natural or man-made disasters that could create structural damage to the children's center or pose health or safety hazards.

a. The emergency plans shall include guidelines for responding to situations involving intruders within the children's center and grounds, intoxicated persons, lost or abducted children, and evacuations.

b. Evacuations shall be practiced periodically.

106.9(2) The emergency plans shall include procedures for annual training regarding the contents and implementation of the plans for staff, volunteers, or others who perform duties under a subcontract with the children's center.

106.9(3) A children's center shall have:

a. Written policies and procedures for medical and dental emergencies; and

b. Sufficient information and authorization to meet the medical and dental emergencies of children.

106.9(4) Emergency telephone numbers shall be readily available, including emergency telephone numbers for parents or guardians.
[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

441—106.10(237B) Buildings. A children's center shall ensure that the facility and grounds, playground surfaces and other areas, and all related equipment are safe and free from hazards.

106.10(1) A children's center shall comply with requirements established by the fire marshal for the applicable type of occupancy and shall comply with any applicable additional fire safety requirements established by local ordinance, including fire inspections.

a. Smoke detectors shall be installed on all levels of the center.

b. The center shall be equipped with fire extinguishers.

c. The center's exits shall be unobstructed at all times.

106.10(2) A children's center shall be structurally sound. Any new facility or existing facility that is extensively renovated shall be constructed in compliance with applicable requirements of the state of Iowa building code established pursuant to Iowa Code chapter 103A and with any local building code in force at the time of construction.

106.10(3) A children's center located in a building built before 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint.

a. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint.

b. In the absence of the determination that peeling or chipping paint is not lead-based, a children's center shall use safe work methods as defined by the state department of public health to eliminate human exposure or likely exposure to lead-based paint hazards.
[**ARC 8009B**, IAB 7/29/09, effective 9/2/09]

These rules are intended to implement Iowa Code chapter 237B.

[Filed ARC 8009B (Notice ARC 7769B, IAB 5/20/09), IAB 7/29/09, effective 9/2/09]

CHAPTER 107
CERTIFICATION OF ADOPTION INVESTIGATORS
[Prior to 2/11/87, Human Services[498]]

441—107.1(600) Introduction. Persons with academic qualifications and adoption work experience may be certified by the department to provide adoption preplacement investigations, postplacement supervision, and reports to the court.

441—107.2(600) Definitions.

"Adoption work experience" means supervised employment in adoption services. Included is direct provision of adoption services, developing adoption policies, conducting training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. For employment, of which only a portion of time was spent on adoptions, only the percent of time related to provision of adoption services shall be included as adoption work experience.

"Certified adoption investigator" means a person authorized by the department to provide background reports on birth parents, adoption preplacement investigations, postplacement supervision, and reports to the court within the state of Iowa.

"Department" means the department of human services.

441—107.3(600) Application.

107.3(1) *Application form.* Application for certification as an adoption investigator shall be made on Form SS-6105-0, Application for Certification of Adoption Investigator. This form may be obtained from the Division of Adult, Children, and Family Services, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114.

107.3(2) *Employees of licensed child placing agencies and the department of human services.* Persons employed as social workers in licensed child placing agencies who meet the requirements for certification in rule 441—107.4(600) are eligible to apply for certification as adoption investigators unless the agency employing them objects in writing. The applicant shall furnish a letter of approval from the agency as part of the certification process.

Persons employed as social workers for the department of human services who meet the requirements for certification in rule 441—107.4(600) are eligible to apply for certification as adoption investigators for services provided outside of their current job duties, unless their current job duties include any of the following:

a. Any of the activities described in rule 441—107.8(600).

b. Immediate supervision of employees engaged in activities described in rule 441—107.8(600).

c. Certification of adoption investigators.

d. Placement of children for adoption.

e. Development of adoption policies used in administration of the adoption program.

441—107.4(600) Requirements for certification.

107.4(1) *Office location.* The applicant shall retain an office in Iowa where all Iowa adoption reports and records of fees are maintained and are available for inspection.

107.4(2) *Education and experience.*

a. If the applicant was initially certified as an adoption investigator before October 1, 1991, the applicant shall have one of the following combinations of education and experience:

(1) Graduation from an accredited four-year college or university and adoption work experience equivalent to a total of three years, full-time experience.

(2) A bachelor's degree in social work from an accredited four-year college or university in a program accredited by the council on social work education and adoption work experience equivalent to a total of two years, full-time experience.

(3) A master's degree in social work from an accredited college or university in a program accredited by the council on social work education and adoption work experience equivalent to a total of one year, full-time experience.

b. If the applicant is initially certified as an adoption investigator on or after October 1, 1991, the applicant shall have one of the following combinations of education and experience:

(1) Graduation from an accredited four-year college or university with a bachelor's degree in social work, psychology, counseling, family therapy, family living, or other family-oriented degree and postgraduation adoption work experience equivalent to a total of three years, full-time experience.

(2) Graduate education in a master's program in social work, psychology, counseling, family therapy, family living, or other family-oriented program from an accredited four-year college or university may be substituted for required adoption work experience on the basis of 30 semester hours for one year of full-time experience, for up to two full years of the required three years of adoption work experience.

(3) A master's degree in social work, psychology, counseling, family therapy, family living, or other family-oriented degree from an accredited college or university and postgraduation adoption work experience equivalent to a total of one year, full-time experience.

107.4(3) *Verification of qualifications.*

a. The applicant shall provide a certified transcript of college credits, and

b. The applicant shall provide a record of all adoption work experience including dates and location, and

c. The applicant shall provide the name(s) of employer(s) and supervisor(s) to enable the department to verify the applicant's adoption work experience, and

d. The applicant shall give names of at least two additional persons as character references who shall be contacted by the certifier.

107.4(4) *Statement of activities and duties.* Prior to certification, the applicant shall prepare a written statement identifying the proposed activities, duties and fees of the applicant as a certified adoption investigator.

a. The statement shall indicate that the services described in rule 441—107.8(600) are being provided by the individual investigator, not a child placing agency, and are not provided in the course of the individual investigator's employment with a child placing agency or the department of human services.

b. The activities and duties identified in the statement cannot exceed the scope of an investigator's services as defined in rule 441—107.8(600).

c. The statement shall include the fee schedule to be used in the determination of a charge for investigative services.

d. A copy of the statement shall be provided to the department to be maintained as a public record.

e. Upon request, this statement shall be provided by the investigator to persons requesting services from the investigator.

107.4(5) *Record checks.* The department of inspections and appeals shall submit record checks for each new applicant and those applying for recertification to determine whether they have any founded child abuse reports or convictions or have been placed on the sex offender registry. The department of inspections and appeals shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B for this purpose. The department shall not certify the applicant with a record of founded child abuse, a criminal conviction, or placement on the sex offender registry as an adoption investigator unless evaluation of the founded abuse or crime indicates approval for certification.

The applicant shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form to be used by the department to assist in the evaluation. Failure of the applicant to complete and return Form 470-2310 within the specified time frame shall result in denial of certification.

The department shall evaluate the nature and seriousness of the founded abuse or crimes, the time elapsed since the commission of the founded abuse or crimes, the circumstances under which the founded abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of founded abuses or crimes committed by the applicant. The department shall notify the applicant of the results of the evaluation using Form 470-2386, Record

Check Decision. The department shall also issue Form 470-2386 when the applicant fails to complete the evaluation form.

Investigators applying for recertification are subject to the same record checks as new applicants. The department shall evaluate only abuses, convictions of crimes, and placement on the sex offender registry since the last record check using the same process.

107.4(6) *Certification actions for nonpayment of child support.* The department shall revoke or deny the issuance or renewal of a certification of an adoption investigator upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

a. The notice required by Iowa Code section 252J.8 shall be served upon the applicant or certified investigator by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rules of Civil Procedure 56.1. Alternatively, the applicant or certified investigator may accept service personally or through authorized counsel.

b. The effective date of the revocation or denial of the certification as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or certified investigator.

c. The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or certified investigator.

d. Applicants and certified investigators shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in these actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

e. An applicant or certified investigator may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

(1) The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

(2) For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a certification, the department 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.

f. The department shall notify the applicant or certified investigator in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of certification or the denial of the issuance or renewal of a certificate of adoption investigator, and shall similarly notify the applicant or certified investigator when the certificate is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

g. Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

441—107.5(600) Granting, denial, or revocation of certification.

107.5(1) *Granting of certification.* When all of the requirements of this chapter are met, certification shall be granted.

107.5(2) *Denial or revocation of certification.*

a. Certification or recertification shall be denied or revoked when one or more of the following conditions exist:

(1) The applicant does not comply with the requirements listed in subrules 107.4(1), 107.4(2), and 107.4(4), and rules 441—107.9(600) and 441—107.10(600).

(2) The applicant does not provide information required in subrule 107.4(3).

(3) The applicant has willfully or knowingly misrepresented information regarding qualifications for certification.

(4) When information about the certified investigator is received and verified by the department of inspections and appeals such as, but not limited to, failure to carry out the activities and duties as stated in this chapter, charging fees in excess of those specified in subrule 107.8(5) and breaches of confidentiality, and the effect of the investigator's actions would be detrimental to any of the parties to the adoption. Complaints involving the reasonable exercise of professional judgment in the denial or approval of a preplacement investigation are not grounds for decertification.

(5) The investigator, after being warned in writing by the licensor, provided incomplete or inadequate information or inaccurate information in required reports as described in rule 441—107.8(600).

(6) The applicant has a founded child abuse or criminal record conviction unless an evaluation of the founded abuse or criminal conviction is conducted by the department of inspections and appeals which concludes that the abuse or crime does not merit prohibition of certification.

(7) The investigator aids or participates in an illegal placement or violates the statutes of Iowa Code chapter 600.

b. If an applicant is denied certification or recertification based on an inability to meet the requirements of subrule 107.4(1), 107.4(2), 107.4(3), 107.4(4), 107.4(5), or 107.4(6), the applicant may reapply when the requirements for certification have been met.

c. Rescinded IAB 8/12/98, effective 10/1/98.

441—107.6(600) Certificate.

107.6(1) *Contents.* Form SS-1204-0, Certificate of Adoption Investigator, shall contain the name of the investigator and the expiration date of the certificate and be signed by a person designated by the director of the department.

107.6(2) *Time limit.* The investigator shall be certified for two years. Certification shall expire at the end of two years unless the investigator has made timely application for recertification. No provisional certificates shall be issued.

107.6(3) *Records of certifications.*

a. The department shall keep records of certifications including the application and verifications.

b. The department shall keep an alphabetical list of certified adoption investigators by districts and shall update the list at least semiannually. Lists of certified adoption investigators shall be furnished to all district offices of the department and to any person who requests a list.

441—107.7(600) Renewal of certification.

107.7(1) *Request for renewal.* A currently certified investigator who wishes to be recertified shall notify the department in writing at least 30 days but no more than 60 days prior to the expiration of the certificate. To be recertified, the person shall submit a new application on Form SS-6105-0, Application for Certification of Adoption Investigator. If no application is submitted, the certification shall expire.

107.7(2) *Evaluation of investigator.* Upon receipt of the request for recertification, the department investigators' records shall be reviewed and evaluated by the licensor to determine whether the requirements of these rules have been met. This evaluation shall include the review of 20 percent, or no fewer than four, of the adoption records opened since the last review for certification and the fees assessed clients. Reports of investigations shall be available to the licensor during the review for recertification, or at any other time upon request by the licensor.

When deficiencies are noted at the time of review, the investigator shall be given 7 to 30 days to meet the standards set forth in 441—Chapter 107. The deficiencies shall be noted in writing and the investigator shall sign a statement that includes agreement to the following:

a. The deficiencies noted by the licensor, including the areas of 441—Chapter 107 which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the deficiencies will be corrected.

When the deficiencies are corrected within the time frame granted, the certificate will be renewed. Deficiencies not corrected within the allowed time frame are grounds for revocation of the investigator's certificate.

107.7(3) *Notification.* The department shall notify the investigator of the decision regarding the initial application, and any applications for recertification, within 60 days of receipt of the application. When the request for recertification is not received prior to the date of expiration, the department shall notify the investigator that the certification has expired.

441—107.8(600) Investigative services.

107.8(1) *Preplacement investigations.* When an adoption investigator provides a preplacement investigation of a prospective adoptive family, the investigation shall meet the requirements of Iowa Code section 600.8(1)*"a,"* including an assessment of the family's ability to parent a child.

a. The preplacement investigation shall include at a minimum two contacts, one face-to-face interview with the applicants and each member of the household and at least one home visit.

b. The investigator shall have on file a written assessment of the family which shall be used to approve or deny a prospective adoptive family. The written assessment (home study) shall include the date the home study was completed, shall be signed by the investigator and the signature notarized. The assessment shall include the following:

(1) Motivation for adoption and whether the family has biological, adopted, or foster children;

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child;

(3) The attitude towards adoption of significant other people involved with the family;

(4) Emotional stability, marital history and assessment of marital relationship, including verification of marriages and divorces, and compatibility of adoptive parent(s);

(5) Ability to cope with problems, stress, frustrations, crises, separation, and loss;

(6) Medical conditions which would affect the applicant's ability to parent a child;

(7) Ability to provide for the child's physical and emotional needs;

(8) Adjustment of biological children and previously adopted children, if any, including their attitudes towards adoption, adjustments in the family and in school;

(9) Capacity to give and receive affection;

(10) Statements from at least three references provided by the family and other unsolicited references;

(11) Attitudes of the adoptive applicants towards the birth parent(s) and the reason(s) the child is available for adoption;

(12) Income information;

(13) Disciplinary practices that will be used;

(14) History of abuse by family members and treatment;

(15) Assessment of commitment to and capacity to maintain other significant relationships;

(16) Substance use or abuse by family members and treatment; and

(17) Recommendations for type of child, number, age, sex, characteristics, and special needs of children best served by this family.

c. Record checks. The certified adoption investigator shall submit record checks for each applicant and for any other adult living in the home of the applicant to determine whether they have founded child abuse reports or criminal convictions. Form 470-0643, Request for Child Abuse Information, and Form 595-1396, Request for Non-Law Enforcement Record Check, shall be used for this purpose.

If there is a record of founded child abuse or a criminal conviction for the applicant, or any other adult living in the home of the applicant, the applicant shall not be approved as an adoptive family, unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

EXCEPTION: The person making the investigation shall not approve a prospective applicant and shall not perform an evaluation if the applicant or any other adult living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."* The person making the investigation shall not approve a prospective applicant and shall not perform an evaluation if the

applicant or any other adult living in the home of the applicant has committed a crime in another state that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

The evaluation shall consider the nature and seriousness of the abuse or crime, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person. The person with the founded child abuse or criminal conviction report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of approval for adoption.

(1) If the applicant or any other adult living in the home of the applicant has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the certified adoption investigator. The certified adoption investigator shall notify the applicant of the results of the evaluation using Form 470-2386, Record Check Decision.

(2) If the applicant or any other adult living in the home of the applicant has a founded child abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the evaluation shall be initially conducted by the certified adoption investigator.

1. If the certified adoption investigator determines that the abuse or crime does warrant prohibition of approval, the certified adoption investigator shall notify the applicant of the results of the evaluation using Form 470-2386, Record Check Decision.

2. If the certified adoption investigator believes that the applicant should be approved despite the abuse or criminal conviction, the certified adoption investigator shall provide copies of the child abuse report or criminal history record, Form 470-2310, Record Check Evaluation, and Form 470-2386, Record Check Decision, to the Department of Human Services, Administrator, Division of Adult, Children and Family Services, Hoover State Office Building, Des Moines, Iowa 50319-0114. Within 30 days the administrator shall determine whether the abuse or crime merits prohibition of approval and shall notify the certified adoption investigator in writing of that decision. The certified adoption investigator shall mail the applicant Form 470-2386, Record Check Decision, when a decision is reached regarding the evaluation of an abuse or crime, or when an applicant fails to complete the evaluation form.

(3) The child abuse and criminal record checks shall be repeated and any founded abuses or convictions of crimes since the last record check shall be evaluated using the same process during the home study update required by Iowa Code section 600.8.

d. Home study updates are required if the home study was written more than one year previously, in accordance with Iowa Code section 600.8. The home study update shall consist of completing the following:

(1) The child abuse and criminal record checks shall be repeated and if there are new founded abuses or conviction of crimes that were not evaluated in the previous home study they shall be evaluated using the process set forth in 107.8(1)*"c."*

(2) One face-to-face visit shall be conducted with the approved family.

(3) The information in the approved home study shall be reassessed.

(4) An updated report of the reassessment and adoptive home study shall be written, dated, signed and notarized and a copy provided to the family.

107.8(2) *Background information investigation.* When an adoption investigator completes a background information investigation on the child to be adopted at the request of the placer, the investigation shall include a complete family medical and mental health history and developmental history of the child to be adopted. A personal interview with each parent of the child must be completed unless a parent's identity or whereabouts is unknown.

107.8(3) *Postplacement investigation.* When an adoption investigator completes postplacement supervision, at least three visits to the adoptive family's home and personal observation of the child are required.

a. Postplacement reports are to be written after each postplacement visit and copies kept in the permanent family file retained by the investigator.

b. Postplacement supervision should assess the placement in the following areas:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the child's placement.

(3) Social, emotional and school adjustment of the child.

(4) Changes that have occurred in the family since placement of the child.

(5) The family's method of dealing with testing behaviors and discipline.

c. Home visits shall be completed at a minimum as follows:

(1) One no later than 30 days after placement.

(2) One no later than 90 days after placement.

(3) A final visit prior to requesting a consent to adopt. Home visits shall be completed as often as necessary if the adoptive family is experiencing problems.

d. A report based on the postplacement visits with recommendations regarding the finalization of the adoption shall be submitted to the court.

107.8(4) *Reports of investigations.* The adoption investigator is authorized to provide reports to the courts concerning the above investigations and reports to the guardian or custodian of the child and the attorney for the adoptive family.

107.8(5) *Fees for services.* Certified investigators may charge a fee for the services described in subrules 107.8(1), 107.8(2), and 107.8(3). The licensor shall review the amount of fees for services charged to families at the time that the investigator's records are reviewed for recertification. Information shall also be retained regarding fees charged to a family by another party and collected by the investigator.

441—107.9(600) Retention of adoption records. The adoption investigator shall maintain a record of each family or child when one or more of the required reports have been completed. The record shall contain copies of all completed reports and a statement of fees charged by the investigator.

107.9(1) *Access to records.* The provisions regarding sealing of and access to adoption records in Iowa Code section 600.16 shall be followed, except that access under subrule 107.9(3) for recertification is permitted.

107.9(2) *Disposition of records.* Upon revocation, denial of renewal, or expiration of certification, all sealed records held by investigators shall be forwarded to the department.

107.9(3) *Access for recertification.* Authorized representatives of the department shall have access to all records of reports completed within a two-year period prior to recertification for purposes of recertification. Authorized representatives shall respect the confidential nature of these records.

441—107.10(600) Reporting of violations. All violations or suspected violations under Iowa Code chapter 600 or 600A which come to the attention of the investigator shall be reported in writing to the district court having jurisdiction of the matter and to the department of human services. The investigator shall maintain copies of these written reports to the court and the department.

441—107.11(600) Appeals. Certified investigators or applicants may appeal decisions of the department according to rules in 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 600.

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CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

[Prior to 7/1/83, Social Services [770] Ch 108]
[Prior to 2/11/87, Human Services [498]]

PREAMBLE

This chapter establishes licensing procedures for all child-placing agencies authorized by Iowa Code chapter 238. Included in this chapter are rules relating to: the licensing process; administration and organization; foster care services; adoption services; and supervised apartment living services.

441—108.1(238) Definitions.

"Administrator" means the person who is designated to have day-to-day responsibility for the administration of a child-placing agency, and who ensures that the mission of the agency and laws relating to the welfare and protection of children are carried out.

"Adoptive applicant" means the person who has requested approval for placement of a child for adoption from a licensed child-placing agency.

"Adoptive family" means an approved person or persons who have a child placed in their home for the purpose of adoption and are being supervised by the agency or who have a child in their home who has been legally adopted and is entitled to the same benefits as a child born to the parents.

"Approved living arrangement" means that the living situation shall be located so as to provide reasonably convenient access to schools, places of employment, or services required by the youth, comply with applicable state and local zoning, fire, and sanitary regulations, and be reasonably priced so as to fit within the youth's budget.

"Caseworker" means the person who works directly with children, their families, and other relevant individuals and who has primary responsibility for the development, implementation, and review of the agency's service plans for the child and parents; or who completes foster care or adoptive family home studies or supervises foster family or adoptive placements; or who supervises children placed in approved supervised apartment living arrangements.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Child-placing agency" means an agency organized within the state of Iowa for the purpose of receiving minor children for placement, supervision, or both in private family homes for foster care; or for adoption; or the placement, supervision, or both of children who are 16 years of age and older living in approved supervised apartment living placements.

"Department" means the department of human services.

"Parent" means custodial and noncustodial parent.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Sibling" means two or more persons having at least one common parent.

"Supervised apartment living placement" means the placement of a child who is at least 16 years of age in an approved living arrangement which provides an environment in which the child can experience living in the community with minimum supervision.

"Volunteer" means any nonpaid person who donates time to an agency, either in working with an individual or groups of clients. A volunteer may also be a student intern.

441—108.2(238) Licensing procedure.

108.2(1) *Right to apply.* Any person or agency has the right to make application for a child-placing license. When applying for a child-placing license, the applicant shall indicate the services for which licensure is being requested.

108.2(2) *Application.* An agency or person applying for a license shall complete Form 470-0723, Application for License or Certificate of Approval. The application shall be completed and signed by the administrator or the appropriate officer and submitted to the department.

a. The applicant shall report withdrawal of an application to the department within 30 days of the withdrawal decision.

b. Each application shall be evaluated by the department to ensure that all requirements are met.

c. The applicant shall provide requested reports and information relevant to the licensing determination to the department.

108.2(3) *Applications for renewal.* Applications for renewal shall be made to the department at least 30 but no more than 90 days before expiration of the license.

108.2(4) *Notification.* Agencies shall be notified of approval or denial within 90 days of application or reapplication.

108.2(5) *Certificate of license.* The department shall issue or renew Form 470-3623, Certificate of License, every three years, without cost, to any child-placing agency which meets the minimum requirements applicable to child-placing agencies as defined by Iowa Code chapter 238 and this chapter. The license shall be posted in a conspicuous place on the licensed premises.

108.2(6) *Provisional license.* A provisional license may be issued to an agency which does not meet all licensing requirements when the failure to meet all licensing requirements does not pose a danger to the health, safety, or well-being of the children being served. It is issued until the agency meets all requirements, up to a maximum time period of one year. A provisional license is issued when the applicant has signed a written statement which includes the following:

a. The deficiencies necessitating the provisional license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(7) *Suspension of a license.* The suspension of a child-placing license prohibits the agency from engaging in any child-placing activities during the period of the suspension. The department shall suspend a license when the agency's failure to meet the requirements poses a danger to the health, safety, or well-being of the children being served. The suspension of a license shall not extend beyond 12 months, and the existence of the condition requiring suspension shall be corrected within a year and documented in the agency's record.

The agency shall submit a written statement for approval by the department. The statement shall include the following:

a. The deficiencies necessitating the suspended license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(8) *Completed corrective action.* When the corrective action plan is completed on or before the date specified on the provisional license or notice of suspension, a full license shall be issued for the remainder of the licensing period.

108.2(9) *Denial or revocation of a license.* The department shall deny an application or reapplication for a license or revoke a license when the applicant fails to meet the licensing requirements or when any of the following conditions exist:

a. The agency is operating without due regard to the health, safety, and well-being of the children being served.

b. A provisional license is not approved.

c. The recipient of a provisional license fails to complete the corrective action plan within the time allowed.

d. An agency with a suspended license fails to complete the corrective action plan on time and a provisional license is not appropriate.

e. The agency misuses public funds.

f. The agency refuses to cooperate with child protective investigations involving children placed by the agency.

g. The agency continuously and significantly violates licensing requirements.

108.2(10) *Method and content of notice.* The notice of denial, revocation, or suspension shall be sent by restricted certified mail and shall include the following:

a. A specific description of the condition requiring the suspension, denial or revocation.

b. The specific laws or rules violated.

c. The effective date of denial, revocation or suspension.

108.2(11) *Right to appeal.* Any agency which disagrees with the department's licensing decision may appeal to the department. The appeal shall be filed within 30 days of receipt of the licensing decision.

441—108.3(238) Administration and organization.

108.3(1) *Statement of purpose.* The agency shall have a written statement of its child-placing philosophy, purpose, and program. The statement shall contain a description of services and methods for service delivery and a description of the persons for whom the services will be provided. The statement shall be available to the public.

108.3(2) *Governing board.* The agency shall have a governing board which, together with the executive, shall be responsible for making policy and for financing and general management of the agency. The governing board may be either the board of directors or the owners of the agency. If the governing board is a board of directors, the following rules shall apply:

a. The agency shall provide for continuity of board membership.

b. The board shall meet regularly for the purpose of ensuring the proper operation of the agency and fulfilling its responsibilities.

c. The minutes of each meeting of the board shall be kept and made a part of the permanent record of the agency.

108.3(3) *Annual report.* A child-placing agency shall require the administrator to submit a written annual report of the agency's activities. The report shall include fiscal and statistical sections indicating receipts and disbursements, number of clients served, and programs. The annual report shall be available to the department.

108.3(4) *Table of organization.* A table of organization, including the identification of lines of responsibility and authority for policy making and service to clients, shall be available to agency staff and to the department.

108.3(5) *Finances.* The licensee shall:

a. Annually develop and implement a plan of financing which is necessary for the operation of the agency in carrying out its programs, ensuring proper care for children, and meeting requirements for licensing.

b. Annually provide either an audit or a detailed financial statement prepared by an independent fiscal agency that provides a review of receipts and disbursements and a statement of fund balances.

c. Retain fiscal records for five years.

108.3(6) *Employment of administrator.* The agency shall employ a qualified administrator and shall delegate to the administrator the responsibility for the administration of the agency. The administrator shall ensure that the mission of the agency and laws relating to the welfare and protection of children are carried out.

108.3(7) *Office space, equipment and supplies.* The agency shall provide and maintain sufficient office space, equipment, and supplies to ensure delivery of services.

441—108.4(238) Staff qualifications. An agency employee or volunteer shall be a person of good character, emotional stability, and have necessary ability, experience, and education to perform the duties assigned. An employee or volunteer shall not have a criminal record or founded child abuse report, unless the department has evaluated the crime or founded report and concluded that the crime or report does not merit prohibition of employment or licensure.

108.4(1) *Contracted employees.* A child-placing agency which contracts for services shall ensure that contracted employees meet the same qualifications, training, and evaluation requirements as those of workers in employed positions. A child-placing agency is responsible for the services provided by contracted providers as well as volunteers and agency employees.

108.4(2) *Qualifications of administrator.* An agency administrator shall possess one of the following:

a. A master's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and two years of experience in a public or private social services agency.

b. A bachelor's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and four years of experience in a public or private social services agency.

108.4(3) *Caseworker qualifications.* Therapy and counseling services, psychosocial evaluation and assessment and care plan development shall be provided by staff who meet one of the following minimum education and experience criteria:

a. Graduation from an accredited four-year college or university and the equivalent of three years of full-time experience in social work or experience in the delivery of human services in a public or private agency. In addition, these individuals shall have been employed by the agency prior to September 1, 1993. Persons meeting this criterion will not be qualified to provide therapy and counseling if they change place of employment.

b. Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work from a program accredited by the council on social work education.

c. Graduation from an accredited four-year college or university with a bachelor's degree in a human service field related to social work and the equivalent of two years of full-time experience in social work or experience in the delivery of human services in a public or private agency.

d. Graduation from an accredited four-year college or university with a master's degree in social work or related human service field.

e. Any equivalent combination of graduate education in the social or behavioral sciences from an accredited four-year college or university and qualifying experience up to a maximum of 30 semester hours for one year of the required experience.

108.4(4) *Person filling more than one position.* A person functioning in more than one position specified by these rules shall meet the requirements for each of the positions the person fills.

441—108.5(238) Staffing requirements.

108.5(1) *Number of staff.* The agency shall employ a sufficient number of competent staff to perform duties as required by licensing rules for those programs operated by the agency. This shall include the following:

a. Administration of services offered by the agency.

b. Selection and appointment of qualified staff.

c. Provision for staff training.

108.5(2) *Staffing caseload.* The agency shall develop a written policy regarding a staffing ratio based on the workload necessary to provide services in accordance with the agency's program statements. The staffing ratio shall take into consideration all of the following:

a. Qualifications of the caseworkers.

b. Types of children served and their special needs.

c. Types and intensity of services to be provided.

d. Distances involved in provision of services.

e. Other functions or responsibilities of the caseworkers.

441—108.6(238) Personnel administration.

108.6(1) *Personnel policies.* An agency shall develop personnel policies in writing that identify responsibilities of the organization and staff. The policies shall specify hours of work, grievance procedures, sick leave, vacation and all other benefits. A copy of the policies shall be made available to the employee at time of hire.

108.6(2) *Job description and evaluation.* There shall be a written job description for each employee, volunteer, and contracted position identifying duties, qualifications, education, training requirements,

and lines of authority. A copy shall be made available to the employees, volunteers, and contracted workers. There shall be a written evaluation of an employee's or contracted worker's performance within six months of being hired or contracted, and annually thereafter.

108.6(3) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted casework staff. The 24 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics, and 2 hours of training related to the identification and reporting of child abuse for all employed or contracted casework staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed or contracted casework staff. The 12 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics and child abuse training every five years in accordance with Iowa Code section 232.69.

The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

108.6(4) *Volunteers.* An agency which utilizes volunteer or student intern staff to work directly with a particular child or group of children shall have a written plan for using these volunteers. This plan shall be given to all volunteer staff and shall indicate that all volunteers are:

a. To be supervised directly by a paid staff member.

b. To be trained and oriented in the philosophy of the agency, the needs of the clients being served, and the methods of meeting these needs.

c. To be subject to the character and reference disclosure and checks required of employed and contracted applicants and employees.

d. To be subject to the same confidentiality rules as paid or contracted staff.

e. To assist and supplement paid staff only, and not replace them.

108.6(5) *Personnel records.* A confidential personnel record shall be maintained for each employee, contracted agent, and volunteer. The record shall contain all of the following information:

a. Name and address.

b. Record of training sessions attended, including dates and content of training.

c. Record of criminal convictions and the department's evaluation of same.

d. Record of founded child abuse reports and the department's evaluation of same.

441—108.7(238) Foster care services.

108.7(1) *Program statement.* An agency authorized to place children in foster care shall have a current written program statement. This statement shall be made available to all agency foster parents, foster children, their parents, referring agencies, and all persons making formal inquiry regarding foster care. The program statement shall include all of the following:

a. Types of foster care provided.

b. Types of children accepted for foster care.

c. Types of services provided to the children, their families, and their foster families.

d. Fees and application costs, if any.

e. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for foster care.

108.7(2) *Agency's authorization to place.* The agency shall obtain a signed placement agreement from the child's custodial parent or legal custodian within 48 hours of placement.

108.7(3) *Preplacement documentation.* Except for emergency placements, a child shall be placed in the agency's foster care program only after the agency determines that its foster care program is an appropriate resource.

108.7(4) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not in the best interest of the child, the reasons shall be documented in the child's record.

108.7(5) *Consideration of racial and cultural identity.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.7(6) *Placement preparation.* An agency shall document the preparation for each child placed in foster care. Preparation shall be appropriate to the child's age, individual needs, the circumstances requiring placement, and the special problems presented. Preparation activities shall, when possible, include:

a. Face-to-face visits.

b. A description provided to the child of the foster family.

c. A description of the child's strengths and needs and safety-related information provided to the foster family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

d. Any other activities deemed significant.

108.7(7) *Initial placement outline.* If a placement outline is not in the child's case permanency plan, a brief outline documenting all of the following shall be entered in the child's case record within five working days after placement:

a. Name, birthdate, sex, race, and other significant identifying information.

b. Date of placement.

c. Name and address of parents or legal guardian.

d. Names and whereabouts of siblings.

e. Religious preference.

f. Immediate and significant health needs including the child's physical and emotional state at the time of placement.

g. The circumstances leading to the need for foster care.

h. Known previous out-of-home placements.

i. The immediate needs of the child and parents and services to be provided to meet these needs.

j. The name, address, and telephone number of the referring agent or worker.

108.7(8) *Education.* Within ten school days of placement, provisions shall be made by the agency for enrollment of each child of school age into a school program.

108.7(9) *Clothing.* An agency shall make provisions for adequate and individualized clothing for each child admitted into foster care.

108.7(10) *Monthly visit.* Each child in care shall be personally visited by the assigned caseworker at least once a month.

108.7(11) *Parent and child contact.* Provisions for contact between parents and children shall be made except where the parental rights have been terminated or where the court has determined that visits or contact are detrimental to the child.

a. If the mother is breastfeeding the child:

(1) An assessment shall be made whether continuation of breastfeeding is in the best interest of the child; and

(2) A plan shall be developed to support the mother's breastfeeding efforts, if appropriate.

b. The parents and child shall be informed of the contact plan in a manner consistent with their capacity to understand.

108.7(12) *Health and dental program.* An agency shall provide for a complete health and dental program for each child. An agency shall have a written procedure for handling medical emergencies on a 24-hour basis. A copy of the procedure shall be given to each foster home.

a. The agency shall obtain written authorization from the parent or legal guardian to provide medical, psychiatric, dental, anesthesia, immunization, substance abuse evaluation, and emergency

surgical treatment. Only the parent or legal guardian shall consent to nonemergency surgery, unless ordered by court. If the child's parent prohibits medical examination, immunization, or treatment based on religious grounds, the agency shall obtain a signed statement from the parent that specifies the prohibitions. In potentially life-threatening situations, the agency shall refer the child's care to appropriate medical and legal authorities.

b. A child shall have a physical examination at least annually. This shall be performed by a licensed physician, physician's assistant or licensed nurse practitioner.

c. A child shall have current immunizations as required by the department of public health. If documentation of prior immunization is unavailable, immunizations shall begin within 30 days of placement, unless contraindicated and unless a statement from a physician to that effect is included in the child's medical record. A statement from physician, referring agency, parent, or guardian indicating immunizations are current is sufficient documentation of immunizations.

d. An agency shall provide for dental examinations and treatment; the initial referral at 12 months of age, the next at 24 months of age, then every 6 months.

e. A health record shall be maintained for each child and shall include all of the following:

(1) Authorization for medical care.

(2) A medical history and copies of required physical examinations.

(3) A record of medical and dental care, treatment and prescribed medication, immunizations, accidents requiring medical treatment, and hospitalizations. At the time of discharge from agency foster care, a summary of this record shall be provided to the legal custodian. Information about drug evaluation or treatment, venereal disease tests, HIV tests, and pregnancy tests shall be excluded.

108.7(13) *Service plan development and review.* The provider shall develop and revise service plans for each child in placement. An initial service plan shall be developed within 30 calendar days of placement in foster care. The provider shall identify qualified persons to monitor the services identified in the service plan to ensure that the plan continues to be necessary, appropriate, and addresses the permanency goal. Service plans shall be developed and reviewed as follows:

a. The service plan shall be developed and revised in collaboration with the referral worker, child, family, and the foster parents unless the service plan contains documentation for the treatment rationale for the lack of involvement of one of these parties. The provider shall document the dates and content of the collaboration on the initial and revised service plans. The provider shall provide a copy of the initial and revised service plans to the child's parent and the referring agency, unless otherwise ordered by the court. The initial and revised service plan shall identify the following:

(1) Strengths and needs of the child and parents.

(2) Goals, which are statements of outcomes to be achieved in meeting the needs of the child including the child's permanency needs.

(3) Objectives, which are specific, measurable and time-limited statements of indicators, levels of competence, or accomplishments which are necessary for progress toward each goal.

(4) Specific treatment service activities to be provided to achieve the objectives.

(5) Designation of the persons responsible for providing the services.

(6) Date of initiation and service plan development.

(7) Anticipated duration of services.

b. All service plans shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services or when the needs of the child or the services necessary for the parents to meet the needs of the child have changed and these changes significantly affect goals, objectives and service activities. The review shall determine if the services continue to be necessary, appropriate and consistent with the child's permanency goal. The reviewer shall revise the service plan to reflect the services that are necessary, appropriate, and consistent with the child's permanency goal.

108.7(14) *Information for foster parents.* At the time of placement, an agency shall provide foster parents with all of the following if known:

a. Name of the child, agency caseworker, and referring agency.

b. Information about the child's known behavioral characteristics including safety-related information, needs, and plans for the child and family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court, or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. Written consent to obtain routine, nonsurgical medical care and to authorize emergency medical and surgical treatment, anesthesia, and immunizations for each child placed in the foster home.

d. A copy of the child's current physical examination and medical history when completed.

As this information becomes available to the agency, foster parents shall be informed immediately.

108.7(15) *Religious policy.* The agency shall have a written policy on religious participation and training for foster children. The agency shall provide the policy to parents and foster parents and shall ensure that the policy is adhered to in each foster home.

108.7(16) *Mail.* There shall be a written policy which ensures that foster children are permitted to send and receive mail, unless documented that this practice is contraindicated.

108.7(17) *Allowance policy.* An agency shall have a written policy addressing payment of and accounting for personal allowances for foster children.

108.7(18) *Reporting hospitalization or death of child.* Any serious injury or illness requiring hospitalization of a child in care shall be reported to the parent and the responsible agency as soon as possible. Efforts to notify parents and responsible agency staff shall be documented in the child's record. The death of a child shall be reported immediately to the parent or next of kin and to the referring agency.

108.7(19) *Foster care records.* The agency shall maintain confidential individual records for each child placed in a foster home. The record shall include:

a. The initial placement outline. (Refer to subrule 108.7(7).)

b. All legal documents pertaining to the child.

c. The child's health record, including psychological and psychiatric reports.

d. The summary narrative which reflects the dates and content of the caseworker's contact regarding the child.

e. Educational records and reports.

f. All service plans developed by the agency.

g. Case permanency plans developed by the referring agency.

h. A record of foster placements made by the agency including foster parents' names and addresses and dates of placements.

108.7(20) *Termination of foster care.* When a foster care placement is terminated, all of the following information shall be documented in the child's record within 30 days:

a. Reason for termination.

b. Current location of the child, unless the child was placed for adoption. In that case the record shall state only that the child was placed for adoption and shall not disclose the identity of the adoptive family unless the adoptive family agrees to disclosure of identity prior to finalizing of adoption.

c. Steps remaining to achieve permanency plan goal.

d. Provisions for follow-up, if any.

e. For unplanned terminations, a summary explaining the circumstances.

441—108.8(238) Foster home studies. The agency shall provide information to prospective foster parents about foster care, agency policies, licensing requirements for foster care, the children needing foster care, the licensing process and the reimbursement rates.

108.8(1) *Licensing procedures.*

a. Availability of applications. The agency may provide Form 470-0689, Foster Family Home License Application, to anyone requesting to be licensed.

b. Licensing study. The agency may complete a licensing study of the family.

c. New applications. If the child-placing agency decides to complete the initial licensing study, the agency shall submit to the department all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include a narrative evaluation of the foster family home which reflects a thorough study of each foster family. The narrative shall document at least two face-to-face interviews with the prospective foster family and at least one face-to-face interview with each member of the household before the placement of a child. At least one interview shall take place in the applicant's home. The narrative summary of the family study shall assess all of the following:

(1) Motivation for foster care.

(2) Family's and extended family's attitude toward accepting foster children.

(3) Family's attitude toward foster children's parents.

(4) Emotional stability, physical health, and compatibility of foster parents, and ways they cope with change and stress.

(5) Adjustment of own children, if any.

(6) Assessment of the child-caring skills, including disciplinary techniques used.

(7) Strengths and weaknesses of each member of the household.

(8) Types of children desired.

(9) Type of children, if any, for whom placement with the family would be appropriate.

(10) Recommendation as to the number, age, sex, characteristics, and special needs of children best served by this family.

(11) Assessment of the need for training and a plan for providing the needed training.

(12) Any other pertinent information that might assist the agency in making the licensing recommendation.

(13) Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B, for this purpose. Each person subject to record checks shall also be fingerprinted for a national criminal history check. The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting. Any criminal or abuse records discovered shall be evaluated according to the procedures in rule 441—113.13(237).

(14) Health of foster parents and impact of medical conditions on their ability to foster a child.

(15) Income information.

(16) Documentation that at least three references have been received and the responses reviewed.

108.8(2) *Licensing decision.* The department shall make the licensing decision and notify the applicant and the child-placing agency within 30 days of the licensing decision. In no case shall a child be placed in a foster home before licensing approval.

a. A full license shall be issued to foster families meeting all necessary criteria for a full licensure.

b. A provisional license may be issued for up to one year if the foster family fails to meet all requirements for licensure. When an agency recommends, because of rule violation, that a foster home receive a provisional license at the time the license is issued or renewed, the agency shall document the violation in the foster home file, and shall send the following to the department:

(1) A copy of the assessment of the rule violation and recommendation.

(2) A copy of the foster home's plan to achieve rule compliance within stipulated time frames.

c. When an agency recommends that a foster home license be denied or revoked, the agency shall send the following documents to the department:

(1) A copy of the assessment of rule compliance and the foster family's reaction to the assessment.

(2) The agency's recommendation and supporting rationale.

(3) Other appropriate documents supporting the findings.

108.8(3) *Reapplications.* At least 30 days before the expiration of the license, the agency shall submit all documents and information required by 441—Chapter 113 pertaining to the licensing and

regulation of foster family homes. This shall include an update of the narrative noting any changes that may have occurred in the foster family's living arrangement or life style and any other pertinent information that might assist in making the licensing decision, including an assessment of the foster family's ability to provide foster care.

108.8(4) *Unannounced visits.* The agency shall conduct at least one annual unannounced visit to each licensed foster family home the agency inspects to meet the requirements of Iowa Code section 237.7.

108.8(5) *Complaints.* When an agency receives a complaint which may indicate possible violation of the foster care licensing rules, the agency shall, within five working days of receiving the complaint, either conduct an investigation to assess compliance with applicable rules or refer the complaint to the department for investigation. If the agency conducts the investigation, the agency shall submit a written report of the investigation to the department within ten working days of receiving the complaint with a statement of rule violation and a recommendation regarding the license of the foster family home. The written report shall be filed in the foster parents' file.

108.8(6) *Foster family training.* The agency shall ensure that each foster home recommended for foster family license has complied with the training requirements in 441—113.8(237).

Within six months of licensure and every five years thereafter, each foster parent shall obtain mandatory reporter training relating to identification and reporting of child abuse.

108.8(7) *Placement agreement.* When a child is placed with a foster family, the agency shall have a signed agreement with each foster family home including the expectations and responsibilities of both the agency and the foster family, the services to be provided, and the financial arrangements for children placed in the home.

108.8(8) *Foster family home records.* The agency shall keep separate records for each foster family home. The agency shall begin the record at the time of application. Foster family home records shall contain:

a. The application.

b. Family assessment.

c. Most recent medical reports on foster family members.

d. Summary of dates and content of worker's contacts relating to licensing or relicensing.

e. Reference letters.

f. Annual assessment of strengths and weaknesses of the foster family relative to the care of individual children placed with them.

441—108.9(238) Adoption services.

108.9(1) *Program statement.* An agency licensed to place children for adoption shall have a current written program statement which shall include all of the following:

a. Types of children to be placed.

b. Eligibility requirements for adoptive families.

c. Services provided during the adoption process.

d. Services to the birth parents upon relinquishment.

e. Postadoption services to adoptive families, if offered.

f. Fees and application costs.

g. A statement that payment of fees does not ensure adoption approval.

h. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for adoption, or other adverse decisions.

The program statement shall be made available to referring agencies and to all persons making formal inquiry regarding adoption.

108.9(2) *Services to birth families.* An agency which offers services to birth parents who are considering relinquishing a child for adoption shall provide a minimum of three hours of counseling, or any additional hours of counseling necessary to assist the parents in making an informed decision regarding their child's adoption, consistent with the child's best interest. The counseling of the birth

parents shall begin when the birth parents begin the intake process. This shall be documented in the service plan format.

a. Intake process. When an agency agrees to provide services to the birth parents, intake interviews shall be conducted, including provision of information to the birth parents regarding the adoption process and their rights and role.

b. Background information. A collection of information about the birth parents and the child shall include, but need not be limited to:

(1) The child's legal status, or due date if unborn.

(2) The child's physical description, medical and mental health history, developmental information, and other pertinent information necessary for a child study.

(3) Identification of any specific needs of the child and the type of family to be considered for adoptive placement.

(4) The birth parents' strengths and needs.

(5) The involvement of the birth parents and significant others in the child's care.

(6) The birth family's physical description, medical and mental health history, educational level, any problematic areas including substance and alcohol abuse.

(7) An affidavit signed by the birth parents regarding wishes for the court to reveal, or not reveal, their names to the child pursuant to Iowa Code chapter 600.

(8) Any additional information the birth family wishes to have included in the child's adoption record.

108.9(3) *Preparation of child for adoptive placement.* Preparing a child, especially an older child, includes activities designed to enable a child to make a transition to an adoptive placement. The activities shall include, but are not limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Preparation of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support group to assist the child in the transition and integration into the adoptive family.

108.9(4) *Services to adoptive applicants.*

a. Application process. Before proceeding with an adoptive home study, the agency shall have received an application for adoption from the person or persons wishing to adopt a child. The application form shall include information about the applicant's intent to become an adoptive parent, and the basic data about the applicant's family, home, financial status, health, and references.

b. Explanation of the adoption process. The agency shall provide the applicant an explanation of the entire adoption process, including the legal procedures, the agency policies and procedures regarding placement of children, and the children available for adoption.

c. Adoptive home study. The home study consists of a family assessment which shall include at least two face-to-face interviews with the applicant and at least one face-to-face interview with each member of the household. At least one interview shall take place in the applicant's home. The assessment shall include, but need not be limited to, the following:

(1) Motivation for adoption and whether the family has biological, adopted or foster children.

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child.

(3) The attitude toward adoption of the significant other people involved with the family.

(4) Emotional stability; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation and loss.

(6) Medical, mental, or emotional conditions which may affect the applicant's ability to parent a child.

(7) Ability to provide for the child's physical and emotional needs and respect the child's cultural and religious identity.

(8) Adjustment of biological and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.

(9) Capacity to give and receive affection.

(10) Statements from at least three references provided by the family and other unsolicited references that the agency may wish to contact.

(11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(12) Income information, ability to provide for a child, and a statement as to the need for adoption subsidy for a special needs child, or children.

(13) Disciplinary practices that will be used.

(14) History of abuse by family members and treatment.

(15) Assessment of, commitment to, and capacity to maintain other significant relationships.

(16) Substance use or abuse by members of the family and treatment.

(17) Recommendations for type of child, number, age, sex, characteristics, and special needs of children best parented by this family.

d. Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B, for this purpose.

If there is a record of founded child abuse or a criminal conviction for the applicant, or anyone living in the home of the applicant, the licensed child-placing agency shall not approve the applicant as an adoptive family, unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

EXCEPTION: The person making the investigation shall not approve a prospective applicant and the department shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."* The person making the investigation shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in another state that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

The evaluation shall consider the nature and seriousness of the abuse or crime, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person. The person with the criminal conviction or founded child abuse report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of approval for adoption.

(1) If the applicant, or anyone living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the licensed child-placing agency. The licensed child-placing agency shall notify the applicant of the results of the evaluation.

(2) If the applicant, or anyone living in the home of the applicant, has a founded child abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the licensed child-placing agency shall initially conduct the evaluation.

1. If the licensed child-placing agency determines that the abuse or crime does warrant prohibition of approval, the licensed child-placing agency shall notify the applicant of the results of the evaluation.

2. If the child-placing agency believes that the applicant should be approved despite the abuse or criminal conviction, the agency shall provide copies of Form 470-2310, Record Check Evaluation,

and Form 470-2386, Record Check Decision, to the Department of Human Services, Administrator, Division of Behavioral, Developmental, and Protective Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Within 30 days, the administrator shall determine whether the abuse or crime merits prohibition of approval and shall notify the child-placing agency in writing of that decision.

The licensed child-placing agency shall also notify the family in writing no later than 30 days after completion of the home study of the agency's decision regarding approval for placement of a child. If the family is denied, the agency shall state the reasons for denial. The agency worker and supervisor shall date and sign the adoptive home study. The agency shall provide a copy of the home study to the family. An agency shall not place a child in an adoptive home before the family is approved, or before a placement agreement is signed by the family and the agency.

e. A home study update is required if the adoptive home study was written more than one year previously, in accordance with Iowa Code section 600.8. The preplacement assessment update shall be conducted by completing the following:

(1) The child abuse and criminal record checks shall be repeated and any abuses or convictions of crimes since the last record check shall be evaluated using the same process.

(2) A minimum of one home visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) A written report of the assessment and updated adoptive home study shall be completed, dated, signed by the worker and the supervisor, and provided to the adoptive family.

108.9(5) *Services to adoptive families.*

a. Preparation of the family includes activities designed to prepare the adoptive family for the placement of a particular child. These activities shall assist the adoptive family in expanding its knowledge and understanding of the child and enhance the family's readiness to accept the child into their family and encourage their commitment. The activities shall include, but not be limited to:

(1) Providing background information on the child and the birth family, including a child study that includes past experiences such as foster and adoptive placements.

(2) Providing information regarding the special needs and characteristics of the child.

(3) Providing information regarding an older child's anticipated behavior.

(4) Discussing the impact that adding a new member to their family may have on all current family members.

(5) Discussing the issues of separation, loss, grief, anger, and guilt that adoptive children experience at various developmental stages.

(6) Providing the family with community resources that are available, such as support groups.

b. Preplacement services include the preplacement visits of the child and approved family and any activities necessary to plan, conduct, and assess these transitional visits before the placement of the child in the adoptive family's home for the purpose of adoption.

c. Postplacement services include postplacement supervision, support, crisis intervention, and required reports to the court. The postplacement services are provided from the time the child is placed with an approved adoptive family until finalization of the adoption occurs.

A minimum of three face-to-face postplacement visits are required, or if the family is experiencing problems, as many as are necessary to support the placement. At least two of the visits shall be in the adoptive home. At a minimum the first visit shall be completed within 30 days after placement; the second visit within 90 days after placement; and the final visit before granting consent to adopt.

Observations made during the home visits shall be recorded in the family's adoption file and used by the agency in making written recommendations to the court regarding finalization of the adoption.

Postplacement supervision should focus on the following:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the placement.

(3) Social, emotional adjustment of the child and school adjustment of a child who is attending a school.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes that have occurred in the family since the placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

d. Postadoption services. The agency shall provide postadoption services to adoptive parents and adoptees, or shall refer adoptive parents and adoptees to other community resources for the services.

108.9(6) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not possible, or is not in the best interest of the children, the reasons shall be documented in the record. Efforts shall be made to provide continued contact between siblings after finalized adoptions if the siblings are not placed together.

108.9(7) *Racial and cultural background.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.9(8) *Religious policy.* There shall be a written policy on religious participation for prospective placing parents, adoptive parents, and adoptees. The policy shall be made available to referral sources as well.

108.9(9) *Adoption records.* The agency shall keep separate records for each prospective, approved, or active adoptive family. Contents of these records shall be as follows:

a. The application.

b. The adoptive home study.

c. Current medical records.

d. All references.

e. All legal documents pertaining to the adoption.

f. Birth family information and background report, including physical descriptions, medical and mental health history, educational level, developmental history, problem areas such as substance or alcohol abuse.

g. Summary narrative on the placement decision and the preplacement and postplacement contacts with the adoptive family and child.

h. Information pertaining to the child including, but not limited to: physical, medical, and mental health; problem areas, including verification of the child's special needs; and whether or not a referral was made to the department for adoption subsidy.

i. In the event a family is not approved for placement of a child, the narrative shall clearly indicate the reason.

j. In the event a family is approved, but no child is placed with them, the narrative shall clearly indicate the reason.

108.9(10) *Right to appeal.* An adoptive applicant or an adoptive family may appeal an adverse decision made by a licensed agency. The appeal shall be filed with the department within 30 days of the notice of decision to the applicant or family by the licensed agency.

108.9(11) *Disposition of records.* When an adoption has occurred, the agency must maintain all records regarding the child, the birth family, and the adoptive family or families, forever. Any subsequent information received following the adoption finalization shall be placed in the adoption record. If the agency closes, all adoption records shall be forwarded to the department.

441—108.10(238) Supervised apartment living placement services. An agency seeking to obtain a child-placing license which authorizes the agency to place or supervise children in supervised apartment living placements shall meet the standards in rules 441—108.2(238) to 441—108.6(238).

108.10(1) *Program statement.* An agency authorized to place or supervise children in supervised apartment living placements shall have a current written program statement which shall be provided to all children placed in supervised apartment living. The statement shall include all of the following:

a. A description of the types of living arrangements approved by the agency.

b. The eligibility requirements for the children who may be placed in a supervised apartment living placement.

c. The means of financial support for the children.

d. The expectations the agency has for children while placed in a supervised apartment living placement.

e. Services provided to the children.

f. Provisions for emergency medical care.

g. A description of the education and community activity options that are available.

108.10(2) *Basis for placement.* Before placing a child in supervised apartment living, an agency shall document all of the following:

a. The child is at least 16 years of age.

b. An initial assessment has been made that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

c. The child has the capacity to function outside the structure of a foster family or group care setting.

d. The selection of a supervised apartment living placement is the most appropriate placement for the child.

e. The child will be involved in school or an educational or vocational program, work, or a combination thereof, as indicated in the child's individual service plan.

f. The child has entered into a mutually agreed-upon written contract with the agency which specifies the responsibilities of the agency and the child. This contract shall be reviewed with the child quarterly.

g. The agency has determined, through a visit to the living arrangement, that the following minimum standards for approval have been met:

(1) The living arrangement provides reasonably convenient access to schools, places of employment, and services required by the child.

(2) The living arrangement is in compliance with the applicable state and local zoning, fire, sanitary, and safety regulations.

(3) The living arrangement is reasonably priced to fit within the child's budget.

h. The agency has determined, based on the criteria in this subrule, that the agency's program can meet the needs of the child.

108.10(3) *Services provided.* The following services are required:

a. Ongoing assessment that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

b. Development of an individual service plan by the agency worker within 30 days of the child's placement. The service plan shall be developed in consultation with the child, the child's family (unless a reason for noninvolvement is documented in the case record), and referring worker and shall be signed by all involved. The individual service plan shall be reviewed and updated quarterly or more often as necessary and shall be signed by all involved. The plan shall document the following:

(1) The goals that are intended to meet the specific needs of the child and the projected dates of accomplishment.

(2) The objectives (action steps) to be taken by the child and the agency and the projected dates of accomplishment to meet the child's goals.

(3) The services and activities necessary to achieve the child's goals and facilitate objectives (action steps), the frequency of services or activities, and the persons responsible.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, and any earned or unearned income or assistance (such as food assistance). The agency worker shall work with the child to ensure that needed items are purchased and that bills are paid.

(5) In the quarterly update, the child's progress toward the goals and objectives and the child's compliance with the service plan.

c. Supervision to assist the child in developing the needed structure to live in this setting and in locating and using other needed services. Supervision shall include guidance, oversight, and behavior monitoring.

(1) If the child is under age 18, supervision shall include a minimum of weekly face-to-face contacts.

(2) For children aged 18 or older, supervision shall include face-to-face contact at least every other week.

(3) Agency staff shall be present on site in a cluster setting at any time when more than one child is present in the living arrangement and shall be available to the children 24 hours a day, seven days a week.

(4) The agency shall provide a means for children in a scattered site setting to contact agency personnel 24 hours a day, seven days a week.

(5) The agency shall ensure that each child has access to and is receiving necessary medical care.

d. Documented observation by the agency worker that:

(1) The living situation is an environment that allows for the child's social and emotional needs to be met;

(2) There is an operating smoke alarm on each level of occupancy;

(3) The child has access to a telephone; and

(4) There is no reasonable cause for believing that the child's mode of living presents any unacceptable risks to the child's health or safety.

108.10(4) *Record.* In addition to any other documentation requirements, an agency shall maintain a record for each child in a supervised apartment living placement. The record shall contain all of the following:

a. The name, date of birth, sex, and address of the child and information on how the child can be contacted.

b. Documentation of financial support sufficient to meet the child's housing, clothing, food, and miscellaneous expenses.

c. Name, address, and telephone number of guardian, if applicable, and referring worker.

d. Medical records.

e. Educational and employment records.

f. All of the individual service plans and updated reviews.

g. Documentation of visits.

108.10(5) *Staffing requirements.* Each child in a supervised apartment living placement shall receive an agreed-upon number of hours of casework services per month. This shall be recorded in the child's individual service plan.

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CHAPTER 109
CHILD CARE CENTERS

[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]
[Prior to 7/1/83, Social Services[770] Ch 109]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to specify minimum requirements for licensed child care centers and preschools and to define those child-caring environments that are governed by the licensing standards. The licensing standards govern licensing procedures, administration, parental participation, personnel, records, health and safety policies, physical facilities, activity programs, and food services.

441—109.1(237A) Definitions.

"Adult" means a person 18 years of age or older.

"Child" means either of the following:

1. A person 12 years of age or younger.

2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

"Child care" means the care, supervision, or guidance of a child by a person other than the parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis in a place other than the child's home, but does not include care, supervision, or guidance of a child by any of the following:

1. An instructional program administered by a public or nonpublic school system accredited by the department of education or the state board of regents or a program provided under Iowa Code sections 279.49 and 280.3A.

2. Any of the following church-related programs:

- An instructional program.
- A youth program other than a preschool, before or after school child care program, or other child care program.
- A program providing care to children on church premises while the children's parents are attending church-related or church-sponsored activities on the church premises.

3. Short-term classes of less than two weeks' duration held between school terms or during a break within a school term.

4. A child care center for sick children operated as part of a pediatrics unit in a hospital licensed by the department of inspections and appeals pursuant to Iowa Code chapter 135B.

5. A program operated not more than one day per week by volunteers that meets all the following conditions:

- Not more than 11 children are served per volunteer.
- The program operates for less than 4 hours during any 24-hour period.
- The program is provided at no cost to the children's parent, guardian, or custodian.

6. A nationally accredited camp.

7. A program administered by a political subdivision of the state which is primarily for recreational or social purposes and is limited to children who are five years of age or older and attending school.

8. An instructional program for children at least four years of age who are attending prekindergarten, as defined by the state board of education, or a higher grade level, administered by a nonpublic school system which is not accredited by the department of education or the state board of regents.

9. An after-school program continuously offered throughout the school year to children who are at least five years of age and enrolled in school and attend the program intermittently, or a summer-only program for such children. The program must be provided through a nominal membership fee or at no cost.

10. A special activity program which meets less than four hours per day for the sole purpose of the special activity. Special activity programs include but are not limited to music or dance classes, organized athletic or sports programs, recreational classes, scouting programs, and hobby or craft clubs or classes.

11. A structured program for the purpose of providing therapeutic, rehabilitative, or supervisory services to children under any of the following:

- A purchase of service or managed care contract with the department.
- A contract approved by a local decategorization governance board.
- An arrangement approved by a juvenile court order.

12. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.

13. A child care facility providing respite care to a licensed foster family home for a period of 24 hours or more to a child who is placed with that licensed foster family home.

14. A program offered to a child whose parent, guardian, or custodian is engaged solely in a recreational or social activity, remains immediately available and accessible on the physical premises on which the child's care is provided, and does not engage in employment while the care is provided. However, if the recreational or social activity is provided in a fitness center or on the premises of a nonprofit organization, the parent, guardian, or custodian of the child may be employed to teach or lead the activity.

"Child care center" or *"center"* means a facility providing child day care for seven or more children, except when the facility is registered as a child development home. For the purposes of this chapter, the word "center" shall apply to a child care center or preschool, unless otherwise specified.

"Child care facility" or *"facility"* means a child care center, a preschool, or a registered child development home.

"Department" means the department of human services.

"Direct responsibility for child care" means being charged with the care, supervision, or guidance of a child.

"Extended evening care" means child care provided by a child care center between the hours of 9 p.m. and 5 a.m.

"Facility" means a building or physical plant established for the purpose of providing child day care.

"Get-well center" means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

"Involvement with child care" means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

"National Health and Safety Performance Standards" means the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs produced by the American Public Health Association and the American Academy of Pediatrics with the support of the Maternal and Child Health Bureau, Department of Health and Human Services.

"Parent" means parent or legal guardian.

"Person subject to an evaluation" means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for licensure or is licensed.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.

"Preschool" means a child day care facility which provides care to children aged three through five, for periods of time not exceeding three hours per day. The preschool's program is designed to help the children develop intellectual, social and motor skills, and to extend their interest in and understanding of the world about them.

"Regulatory fee" means the amount payable to the department for licensure of a child care center based on the capacity of the center.

"Transgression" means the existence of any of the following in a person's record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person's continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

"Unrestricted access" means that a person has contact with a child alone or is directly responsible for child care.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 0030C**, IAB 3/7/12, effective 5/1/12]

441—109.2(237A) Licensure procedures.

109.2(1) *Application for license.*

a. Any adult or agency has the right to apply for a license. The application for a license shall be made to the department on Form 470-0722, Application for a License to Operate a Child Care Center, provided by the department.

b. Requested reports including the fire marshal's report and other information relevant to the licensing determination shall be furnished to the department upon application and renewal. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings under 661—Chapter 5 is considered appropriate for use by a child care facility.

c. When a center makes a sufficient application for an initial license, it may operate for a period of up to 120 calendar days from the date of issuance of Form 470-4690, Permission to Open Without a License, pending a final licensing decision. A center has made a sufficient application when it has submitted the following to the department:

(1) An application for a license.

(2) An approved fire marshal's report.

(3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.

(4) Information sufficient to determine that the center director meets minimum personnel qualifications.

d. Applicants shall be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued Form 470-4690, Permission to Open Without a License, the applicant shall be notified of approval or denial within 120 calendar days of the date of issuance of Form 470-4690.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

e. The department shall not act on a licensing application for 12 months after an applicant's child care center license has been denied or revoked.

f. When the department has denied or revoked a license, the applicant or person shall be prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

109.2(2) *License.*

a. An applicant showing full compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(7) to the department by the date due, shall be issued a license for 24 months. In determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department shall make the final decision.

b. A new license shall be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license shall be applied for when another adult or agency assumes ownership or legal responsibility for the center.

109.2(3) *Provisional license.*

a. A provisional license may be issued or a previously issued license may be reduced to a provisional license for a period up to one year when the center does not meet all standards imposed by law and these rules.

b. A provisional license shall be renewable when written plans giving specific dates for completion to bring the center up to standards are submitted to and approved by the department. A provisional license shall not be reissued for more than two consecutive years when the lack of compliance with the same standards has not been corrected within two years.

c. When the center submits documentation or it can otherwise be verified that the center fully complies with all standards imposed by law or these rules, the license shall be upgraded to a full license.

109.2(4) *Denial.* Initial applications or renewals shall be denied when:

a. The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not received by the department's division of fiscal management by the due date indicated on Form 470-4834, Child Care Center Licensing Fee Invoice.

109.2(5) *Revocation and suspension.* A license shall be revoked or suspended if corrective action has not been taken when:

a. The center does not comply with center licensing laws or these rules.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of the children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(6) *Adverse actions.*

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

b. An applicant or licensee affected by an adverse action may request a hearing by means of a written request directed to the Department of Human Services, Appeals Section, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The request shall be submitted within 30 days after the date the department mailed the official notice containing the nature of the denial, revocation, or suspension.

c. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license shall be conspicuously posted at the main entrance to the facility where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny, suspend or revoke the license. If the action to deny, suspend, or revoke is upheld, the center shall return the license to the department.

d. If the center's license is denied, suspended or revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides child care. The center shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

109.2(7) *Regulatory fees.* For relicensures with an effective date on or after August 1, 2010, as indicated on the license certificate, and for initial applications for licensure submitted on or after June 1, 2010, a fee based upon center capacity is due to the department before the issuance of the license in accordance with this subrule.

a. *Fee structure.* The amount of the fee is based on the capacity of the center as indicated below:

Center Capacity	Fee Amount
0 to 20 children	$50
21 to 50 children	$75
51 to 100 children	$100
101 to 150 children	$125
151 or more children	$150

b. *Determination of capacity.* The licensing consultant shall determine center capacity by dividing the amount of usable space by the amount of space required per child, as specified in subrule 109.11(1) and subparagraphs 109.11(3)*"a"*(2) and (3). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) and subparagraphs 109.11(3)*"a"*(2) and (3) are maintained.

c. *Notification.* Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee shall sign and provide Form 470-4834, Child Care Center Licensing Fee Invoice, to the center.

d. *Payment.* The center shall return Form 470-4834 to the department with the licensing fee payment within 30 calendar days from the date of the licensing consultant's or designee's signature on Form 470-4834. Payment may be in the form of cash, check, money order, or cashier's check.

(1) Payment must be received before the department will issue a full or provisional license.

(2) Regulatory fees are nonrefundable and nontransferrable.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 1209C**, IAB 12/11/13, effective 2/1/14]

441—109.3(237A) Inspection and evaluation. The department shall conduct an on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and shall determine compliance with licensing standards imposed by licensing laws and these rules when a complaint is received.

109.3(1) At least one unannounced on-site visit shall be conducted each calendar year.

109.3(2) After each visit and complaint, the department shall document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

109.3(3) The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and complaints shall be available to the public. However, the identity of the complainant shall be withheld unless expressly waived by the complainant.

441—109.4(237A) Administration.

109.4(1) *Purpose and objectives.* Incorporated and unincorporated centers shall submit a written statement of purpose and objectives. The plan and practices of operation shall be consistent with this statement.

109.4(2) *Required written policies.* The child care center owner, board or director shall:

a. Develop fee policies and financial agreements for the children served.

b. Develop and implement policies for enrollment and discharge of children, field trips and non-center activities, transportation, discipline, nutrition, and health and safety policies.

c. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.

d. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of 441—Chapter 109 where applicable to staff.

e. Develop and implement a written plan for ongoing training and staff development in compliance with professional growth and development requirements established by the department in rule 441—109.7(237A).

f. Make available for review a copy of the center policies and program to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

g. Develop and implement a policy for responding to incidents of biting that includes the following elements.

(1) An explanation of the center's perspective on biting.

(2) A description of how the center will respond to individual biting incidents and episodes of ongoing biting.

(3) A description of how the center will assess the adequacy of caregiver supervision and the context and the environment in which the biting occurred.

(4) A description of how the center will respond to the individual child or caregiver who was bitten.

(5) A description of the process for notification of parents of children involved in the incident.

(6) A description of how the incident will be documented.

(7) A description of how confidentiality will be protected.

(8) A description of first-aid procedures that the center will use in response to biting incidents.

h. Develop a policy to ensure that people do not have unauthorized access to children at the center. The policy shall be subject to review for minimum safety standards by the licensing consultant. The policy shall include but is not limited to the following:

(1) The center's criteria for allowing people to be on the property of the facility when children are present.

(2) A description of how center staff will supervise and monitor people who are permitted on the property of the center when children are present, but who have not been cleared for involvement with child care through the formal record check process as outlined in subrule 109.6(6). The description shall include definitions of "supervision" and "monitoring."

(3) A description of how responsibility for supervision and monitoring of people in the center will be delegated to center staff, which includes provisions that address conflicts of interest.

(4) A description of how the policy will be shared with parents, guardians, and custodians of all children who are enrolled at the center.

109.4(3) *Required postings.*

a. Postings are required for the certificate of license, notice of exposure of children to a communicable disease, and notice of action to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status. The center's license, reflecting current regulatory status, and all other required postings shall be conspicuously placed at the main entrance to the center. If the center is located in a building used for additional purposes and shares the main entrance to the building, the required postings shall be conspicuously placed in the center in an area that is frequented daily by parents or the public.

b. Postings are required for mandatory reporter requirements, the notice of availability of the handbook required in subrule 109.4(5), and the program activities and shall be placed in an area that is frequented daily by parents or the public.

109.4(4) *Mandatory reporters.* Requirements and procedures for mandatory reporting of suspected child abuse as defined in Iowa Code section 232.69 shall be posted where they can be read by staff and parents. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

109.4(5) *Handbook.* A copy of Form SS-0711, Child Care Centers and Preschools Licensing Standards and Procedures, shall be available in the center, and a notice stating that a copy is available for review upon request from the center director shall be conspicuously posted. The name, office mailing address and telephone number of the child care consultant shall be included in the notice.

109.4(6) *Certificate of license.* The child care license shall be posted in a conspicuous place and shall state the particular premises in which child care may be offered and the number of children who may be cared for at any one time. Notwithstanding the requirements in rule 441—109.8(237A), no greater number of children than is authorized by the license shall be cared for at any one time.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 1209C**, IAB 12/11/13, effective 2/1/14]

441—109.5(237A) Parental participation.

109.5(1) *Unlimited access.* Parents shall be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider, unless parental contact is prohibited by court order. The provider shall inform all parents of this policy in writing at the time the child is admitted to the center.

109.5(2) *Parental evaluation.* If requested by the department, centers shall assist the department in conducting an annual survey of parents being served by their center by providing to parents Form 470-3409, Parent Survey: Child Care Centers. The department shall notify centers of the time frames for distribution and completion of the survey and the procedures for returning the survey to the department. The purpose of the survey shall be to increase parents' understanding of developmentally appropriate and safe practice, solicit statewide information regarding parental satisfaction with the quality of care being provided to children and obtain the parents' perspective regarding the center's compliance with licensing requirements.

441—109.6(237A) Personnel. The board or director of the center shall develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

109.6(1) *Center director requirements.* Centers that have multiple sites shall have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and administering programs. The director shall ensure services are provided for the children within the framework of the licensing requirements and the center's statement of purpose and objectives. The center director shall have overall responsibility for carrying out the program and ensuring the safety and protection of the children. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the director meets the following minimum qualifications:

a. Is at least 21 years of age.

b. Has obtained a high school diploma or passed a general education development test.

c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, record keeping, or budgeting or has one year of administrative-related experience.

d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's training for the mandatory reporting of child abuse.

e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For directors in centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(2) *On-site supervisor.* The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of eight hours of the center's hours of operation. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the on-site supervisor meets the following minimum qualifications:

a. Is an adult.

b. Has obtained a high school diploma or passed a general education development test.

c. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's mandatory reporting of child abuse.

d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 75 points, a minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For on-site supervisors in centers predominantly serving children with special needs, the on-site supervisor may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For on-site supervisors in centers serving predominantly school-age children, the on-site supervisor may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(3) *Director and on-site supervisor functions combined.* In a center where the functions of the center director and the on-site supervisor are accomplished by the same person, the educational and experience requirements for a center director shall apply. If the center director is serving in the role of the on-site supervisor, the director shall be on site daily either during the hours of operation or a minimum of at least eight hours of the center's hours of operation. If the staff person designated as the on-site supervisor is temporarily absent from the center, another responsible adult staff shall be designated as the interim on-site supervisor.

109.6(4) *Transition period for staff.* In achieving the qualifications outlined in rule 441—109.6(237A), staff hired prior to April 1, 1998, shall obtain the education, experience or child-developmental training sufficient to meet the required point totals by April 1, 1999.

109.6(5) *Volunteers and substitutes.* A volunteer shall be at least 16 years of age. All volunteers and substitutes shall:

a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer or substitute has been informed of the volunteer's or substitute's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

(1) The volunteer or substitute is included in meeting the required child-to-staff ratio;

(2) The volunteer or substitute has direct responsibility for a child or children; or

(3) The volunteer or substitute has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(5)*"a"* and *"b"* and documentation of any record check process. The record shall be maintained as required in paragraph 109.9(1)*"b."*

109.6(6) *Record checks.*

a. *Applicability.*

(1) Criminal and child abuse record checks shall be conducted for:

1. Each owner, director, staff member, substitute, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

2. Anyone living in the child care facility who is 14 years of age or older.

(2) Parents, guardians, and custodians are exempt from the record check process in relation to access to their own children or wards.

(3) Professional staff who hold a current, valid license issued by the educational examiners board are exempt from the record check process in relation to children in the center to whom they provide professional services consistent with Iowa Code chapter 272 and rules adopted by the educational examiners board.

b. *Authorization.* The person subject to record checks shall complete Form 595-1396, DHS Criminal History Record Check Form B, and any other forms required by the department of public safety to authorize the release of records.

c. *Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, shall be completed before the person's involvement with child care at the center. Iowa records checks shall be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center shall send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph (1), the department shall conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. When the department conducts the records check, the fee shall be $25 for each record check through June 30, 2010, and $35 effective July 1, 2010. The center shall submit the fee before the department initiates the record check process. Payment must be in the form of cash, check, money order, or cashier's check. The department may access SING to conduct the records check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

(3) Centers that participate in student intern programs may seek a waiver for substitution of the state record check process with a check performed by the student's educational institution. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

d. *National criminal history checks.* National criminal history checks based on fingerprints are required for all persons subject to record checks under this subrule effective with a center's initial licensure or relicensure on or after June 1, 2010. The national criminal history check shall be repeated for each person every four years and when the department or center becomes aware of any new

transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks. Fingerprints may be taken by law enforcement agencies, by agencies or companies that specialize in taking fingerprints, or by center staff or subcontractors who have received appropriate training in the taking of fingerprints.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center shall provide fingerprints to the department of public safety no later than 30 days after the subject's approval for employment at the center. The center shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(5) Centers that participate in student intern programs may seek a waiver to substitute the fingerprint-based check of the FBI national criminal database performed by the student's educational institution for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(6) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide the following information in writing upon a center's request, using Form 470-4896, National Criminal History Check Confirmation:

1. Date of most recent national criminal history check conducted by the center on the person in question, and

2. Whether or not the national check process resulted in clearance of the person for involvement with child care.

(7) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, shall send a copy of the results to the department for evaluation. The department shall determine whether or not the person may be involved with child care.

(8) A center shall submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license on or after June 1, 2010. EXCEPTION: Centers that have an initial or renewal licensure date of June 1, 2010, shall have until July 1, 2010, to submit the fingerprints to the department of public safety.

e. Mandatory prohibition. A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

(1) Founded child or dependent adult abuse that was determined to be sexual abuse.

(2) Placement on the sex offender registry.

(3) Felony child endangerment or neglect or abandonment of a dependent person.

(4) Felony domestic abuse.

(5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

(6) Forcible felony.

f. Mandatory time-limited prohibition.

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.

2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period imposed pursuant to 109.6(6)*"f"*(1), the person may request the department to perform an evaluation under paragraph 109.6(6)*"g"* to determine whether prohibition of the person's involvement with child care continues to be warranted.

g. Evaluation required. For all other transgressions, and as requested under subparagraph 109.6(6)*"f"*(2), the department shall notify the affected person and the licensee that an evaluation shall be conducted to determine whether prohibition of the person's involvement with child care is warranted.

(1) The person with the transgression shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form by the specified date shall result in denial or revocation of the license or denial of employment.

(2) The department may use information from the department's case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.
2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.
3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.
4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. Evaluation decision. Within 30 days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall make a decision on the person's involvement with child care. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department shall mail to the individual on whom the evaluation was completed Form 470-2386, Record Check Decision, that explains the decision reached regarding the evaluation of the transgression and Form 470-0602, Notice of Decision.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department shall send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter shall inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

i. *Notice to parents.* The administrator of the department shall notify the parents, guardians, and legal custodians of each child for whom the person provides child care if there has been founded child abuse committed by an owner, director, or staff member of the child care center. The center shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

109.6(7) *Use of controlled substances and medications.* All owners, personnel, and volunteers shall be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 9441B**, IAB 4/6/11, effective 6/1/11; **ARC 0418C**, IAB 10/31/12, effective 1/1/13; **ARC 1209C**, IAB 12/11/13, effective 2/1/14]

441—109.7(237A) Professional growth and development. The center director, on-site supervisor, and staff counted as part of the staff ratio shall meet the following minimum staff training requirements:

109.7(1) *Required training within the first six months of employment.* During their first six months of employment, all staff shall receive the following training:

a. Two hours of Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions and infectious disease control.

109.7(2) *Center directors and staff employed 20 hours or more per week.* The requirements of this subrule apply to all center directors, regardless of whether the director works on a full-time or part-time basis.

a. During their first year of employment, all center directors and all staff employed 20 hours or more per week shall receive the following training:

(1) Certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(2) Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(3) Ten contact hours of training from one or more of the following content areas:

1. Planning a safe, healthy learning environment (includes nutrition).
2. Steps to advance children's physical and intellectual development.
3. Positive ways to support children's social and emotional development (includes guidance and discipline).
4. Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
5. Strategies to manage an effective program operation (includes business practices).
6. Maintaining a commitment to professionalism.
7. Observing and recording children's behavior.
8. Principles of child growth and development.

(4) At least four hours of the ten contact hours of training shall be received in a group setting as defined in subrule 109.7(7). Six hours may be received in self-study using a training package approved by the department as defined in subrule 109.7(8). Training received for cardiopulmonary resuscitation (CPR), first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(5) Center directors and on-site supervisors shall receive all ten hours of training in a group setting as defined in subrule 109.7(7).

(6) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the first year's ten contact hours of training waived.

b. Following their first year of employment, all center directors and all staff who are employed 20 hours or more a week shall:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Receive six contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)*"a"*(3). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(3) Center directors and on-site supervisors shall receive eight contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)*"a"*(3). At least four of the eight contact hours shall be in a group setting as defined in subrule 109.7(7).

109.7(3) *Staff employed less than 20 hours per week.*

a. During their first year of employment, all staff who are employed less than 20 hours a week shall receive the following training:

(1) Five contact hours of training from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence.

(2) At least two of the five contact hours shall be in a sponsored group setting.

(3) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the five contact hours required in the first year waived.

b. Following their first year of employment, all staff who are employed less than 20 hours a week shall:

(1) Maintain current certification for Iowa's training for mandatory reporting of child abuse.

(2) Receive four contact hours of training annually from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence. At least two of the four contact hours shall be in a sponsored group setting.

109.7(4) *Staff employed in centers that operate summer-only programs.* Staff who are employed in centers that operate only in the summer months when school is not in session shall receive the following training:

a. Two hours of Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions and infectious disease control.

c. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall have certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

d. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall receive certification in infant, child and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

109.7(5) *Training plans.* Training shall supplement educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

109.7(6) *Substitution.* A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

109.7(7) *Group training.* Training received in a group setting is not self-study, but is training received with other adults, either in or out of the child care center.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed or obtained with the written permission of one of the following entities:

(1) An accredited university or college.

(2) A community college.

(3) Iowa State University Extension.

(4) A child care resource and referral agency.

(5) An area education agency.

(6) The regents' center for early developmental education at the University of Northern Iowa.

(7) A hospital (for health and safety, first-aid, and CPR training).

(8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).

(9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.

(10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.

(11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

(12) The Iowa department of public health, department of education, or department of human services.

(13) Head Start agencies or the Head Start technical assistance system.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph *"a"* or an entity approved under paragraph *"g."* Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

(1) The training meets the requirements in subrule 109.7(9);

(2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and

(3) The training organization meets the requirements listed in this subrule or is approved by the department.

d. The department will not approve more than eight hours of training delivered in a single day.

e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(8) *Self-study training.*

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

(1) Department child care licensing consultants,

(2) Iowa State University Extension, or

(3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(9) *Approved training.* Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

(1) Iowa child care regulatory standards;

(2) The Iowa early learning standards; and

(3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

(1) The name of the participant.

(2) The title of the training.

(3) The dates of training.

(4) The content area addressed.

(5) The name of the training organization.

(6) The name of the instructor.

(7) The number of contact hours.

(8) An indication of whether the training was delivered through self-study or in a group setting.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.8(237A) Staff ratio requirements.

109.8(1) *Staff requirements.* Persons counted as part of the staff ratio shall meet the following requirements:

a. Be at least 16 years of age. If less than 18 years of age, the staff shall be under the direct supervision of an adult.

b. Be involved with children in programming activities.

c. At least one staff person on duty in the center and outdoor play area when children are present and present on field trips shall be over the age of 18 and hold current certification in first aid and cardiopulmonary resuscitation (CPR) as required in rule 441—109.7(237A).

109.8(2) *Staff ratio.* The staff-to-child ratio shall be as follows:

Age of children	Minimum ratio of staff to children
Two weeks to two years	One to every four children
Two years	One to every six children
Three years	One to every eight children
Four years	One to every twelve children
Five years to ten years	One to every fifteen children
Ten years and over	One to every twenty children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group. If children three years of age and under are included in the combined age group, the staff ratio for children aged three and under shall be maintained for these children. Preschools shall have staff ratios determined on the age of the majority of the children, including children who are three years of age.

b. If a child between the ages of 18 and 24 months is placed outside the infant area, as defined at subrule 109.11(2), the staff ratio of 1 to 4 shall be maintained as would otherwise be required for the group until the child reaches the age of two.

c. Every child-occupied program room shall have adult supervision present in the room.

d. During nap time, at least one staff shall be present in every room where children are resting. Staff ratio requirements may be reduced to one staff per room where children are resting for a period of time not to exceed one hour provided staff ratio coverage can be maintained in the center. The staff ratio shall always be maintained in the infant area.

e. The minimum staff ratio shall be maintained at mealtimes and for any outdoor activities at the center.

f. When seven or more children over the age of three are present on the licensed premises or are being transported in one vehicle, at least two adult staff shall be present. Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school. When a center contracts with another entity to provide transportation other than for the purpose of transporting school-age children to or from school, at least one adult staff in addition to the driver shall be present if at least seven children provided care by the center are transported.

g. Any child care center-sponsored program activity involving five or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children.

h. For a period of two hours or less at the beginning or end of the center's hours of operation, one staff may care for six children or less, provided no more than two of the children are under the age of two years.

i. For centers or preschools serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

441—109.9(237A) Records.

109.9(1) *Personnel records.* The center shall maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file shall contain, at a minimum, the following:

a. A statement signed by each individual indicating whether or not the individual has any conviction of violating any law in any state or has any record of founded child abuse or dependent adult abuse in any state.

b. Copies of all records checks kept in accordance with state and federal law regarding confidentiality of records checks. These records shall include:

(1) A copy of Form 595-1396, DHS Criminal History Record Check Form B, or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of Form 470-0643, Request for Child Abuse Information, when applicable.

(3) Copies of the results of Iowa records checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a records check, regardless of findings.

c. Reserved.

d. A physical examination report. Personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory

Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to beginning employment by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

e. Documentation showing the minimum staff training requirements as outlined at rule 441—109.7(237A) are met, including current certifications in first aid and cardiopulmonary resuscitation (CPR) and Iowa's training for the mandatory reporting of child abuse.

f. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

109.9(2) *Child's file.* Centers shall maintain sufficient information in a file for each child, which shall be updated at least annually or when the parent notifies the center of a change or the center becomes aware of a change, to ensure that:

a. A parent or an emergency contact authorized by the parent can be contacted at any time the child is in the care of the center.

b. Appropriate emergency medical and dental services can be secured for the child while in the center's care.

c. Information is available in the center regarding the specific health and medical needs of a child, including information regarding any professionally prescribed treatment. Information shall include a physical examination report as required at subrule 109.10(1). For a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

d. A child is released only to authorized persons.

e. Documentation of injuries, accidents, or other incidents involving the child is maintained.

f. Parent authorization is obtained for a child to attend center-sponsored field trips and non-center activities. If parental authorization is obtained on an authorization form inclusive of all children participating in the activity, the authorization form shall be kept on file at the center.

109.9(3) *Immunization certificates.* Signed and dated Iowa immunization certificates, provided by the state department of public health, shall be on file for each child enrolled as prescribed by the department of public health at 641—Chapter 7.

109.9(4) *Daily activities.* For each child under two years of age, the center shall make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 0996C**, IAB 9/4/13, effective 11/1/13]

441—109.10(237A) Health and safety policies. The child care center shall establish definite health policies, including the criteria for excluding a sick child from the center. The policies shall be consistent with the recommendations of the National Health and Safety Performance Standards and shall include, but are not limited to:

109.10(1) *Physical examination report.*

a. *Preschool-age children.* For each child five years of age and younger not enrolled in kindergarten, the child care center shall require an admission physical examination report, submitted within 30 days from the date of admission, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner. The date of the physical examination shall be no more than 12 months prior to the first day of attendance at the center. The written report shall include past health history, status of present health including allergies, medications, and acute or chronic conditions, and recommendations for continued care when necessary. Annually thereafter, a statement of health condition, signed by a licensed medical doctor, doctor of osteopathy, physician's

assistant or advanced registered nurse practitioner, shall be submitted that includes any change in functioning, allergies, medications, or acute or chronic conditions.

b. *School-age children.* For each child five years of age and older and enrolled in school, the child care center shall require, prior to admission, a statement of health status signed by the parent or legal guardian that certifies that the child is free of communicable disease and that specifies any allergies, medications, or acute or chronic conditions. The statement from the parent shall be submitted annually thereafter.

c. *Religious exemption.* Nothing in this rule shall be construed to require medical treatment or immunization for staff or the child of any person who is a member of a church or religious organization which has guidelines governing medical treatment for disease that are contrary to these rules. In these instances, an official statement from the organization shall be incorporated in the personnel or child's file.

109.10(2) *Medical and dental emergencies.* The center shall have sufficient information and authorization to meet the medical and dental emergencies of children. The center shall have written procedures for medical and dental emergencies and shall ensure, through orientation and training, that all staff are knowledgeable of and able to implement the procedures.

109.10(3) *Medications.* The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications, including the following:

a. All medications shall be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so they are inaccessible to children and the public. Nonprescription medications shall be labeled with the child's name.

b. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

c. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

109.10(4) *Daily contact.* Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior which may adversely affect the child or the group. The center shall post notice at the main entrance to the center where it is visible to parents and the public of exposure of a child receiving care by the center to a communicable disease, the symptoms, and the period of communicability. If the center is located in a building used for other purposes and shares the main entrance to the building, the notice shall be conspicuously posted in the center in an area that is frequented daily by parents or the public.

109.10(5) *Infectious disease control.* Centers shall establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

109.10(6) *Quiet area for ill or injured.* The center shall provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person shall be notified of the child's status in the event of a serious illness or emergency.

109.10(7) *Staff hand washing.* The center shall ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease. All staff shall wash their hands at the following times:

a. Upon arrival at the center.

b. Immediately before eating or participating in any food service activity.

c. After diapering a child.

d. Before leaving the rest room either with a child or by themselves.

e. Before and after administering nonemergency first aid to a child if gloves are not worn.

f. After handling animals and cleaning cages.

109.10(8) *Children's hand washing.* The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing and one for rinsing may be used in place of running water. Children's hands shall be washed at the following times:

a. Immediately before eating or participating in any food service activity.

b. After using the rest room or being diapered.

c. After handling animals.

109.10(9) *First-aid kit.* The center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

109.10(10) *Recording incidents.* Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident. Incidents resulting in an injury to a child shall be reported to the parent on the day of the incident. Incidents resulting in a serious injury to a child or incidents resulting in a significant change in the health status of a child shall be verbally reported to the parents, guardians, and legal custodians immediately. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior shall be notified immediately after the incident. A written report, fully documenting every incident, shall be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident and a copy shall be retained in the child's file.

109.10(11) *Smoking.* Smoking and the use of tobacco products shall be prohibited at all times in the center and in every vehicle used to transport children. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during hours of operation of the center. Nonsmoking signs shall be posted at every entrance of the child care center and in every vehicle used to transport children. All signs shall include:

a. The telephone number for reporting complaints, and

b. The Internet address of the department of public health (www.iowasmokefreeair.gov).

109.10(12) *Transportation.* As outlined in Iowa Code section 321.446, all children transported in a motor vehicle subject to registration, except a bus, shall be individually secured by a safety belt, safety seat, or harness in accordance with federal motor vehicle safety standards and the manufacturer's instructions.

a. Children under the age of 6 shall be secured during transit in a federally approved child restraint system. Children under 1 year of age and weighing less than 20 pounds shall be secured during transit in a rear-facing child restraint system.

b. Children under the age of 12 shall not be located in the front seating section of the vehicle.

c. Drivers of vehicles shall possess a valid driver's license and shall not operate a vehicle while under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

d. Vehicles that are owned or leased by the center shall receive regular maintenance and inspection according to manufacturer-recommended guidelines for vehicle and tire maintenance and inspection.

109.10(13) *Field trip emergency numbers.* Emergency telephone numbers for each child shall be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

109.10(14) *Pets.* Animals kept on site shall be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets, reptiles, including turtles, or birds of the parrot family shall be kept on site. Pets shall not be allowed in kitchen or food preparation areas.

109.10(15) *Emergency plans.*

a. The center shall have written emergency plans for responding to fire, tornado, flood (if area is susceptible to flood), intruders within the center, intoxicated parents and lost or abducted children.

In addition, the center shall have guidelines for responding or evacuating in case of blizzards, power failures, bomb threats, chemical spills, earthquakes, or other disasters that could create structural damage to the center or pose health hazards. If the center is located within a ten-mile radius of a nuclear power plant or research facility, the center shall also have plans for nuclear evacuations. Emergency plans shall include written procedures including plans for transporting children and notifying parents, emergency telephone numbers, diagrams, and specific considerations for immobile children.

b. Emergency instructions, telephone numbers, and diagrams for fire, tornado, and flood (if area is susceptible to floods) shall be visibly posted by all program and outdoor exits. Emergency plan procedures shall be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills shall be maintained for the current and previous year.

c. The center shall develop procedures for annual staff training on these emergency plans and shall include information on responding to fire, tornadoes, intruders, intoxicated parents and lost or abducted children in the orientation provided to new employees.

d. The center shall conduct a daily check to ensure that all exits are unobstructed.

109.10(16) *Supervision and access.*

a. The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

b. Any person in the center who is not an owner, staff member, substitute, or volunteer who has a record check and department approval to be involved with child care shall not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. Persons who are exempt from the record check process are granted access in accordance with 109.6(6)*"a"*(2) unless the provisions of paragraph 109.10(16)*"d"* apply.

d. A sex offender who has been convicted of a sex offense against a minor and who is required to register with the Iowa sex offender registry under the provisions contained in Iowa Code chapter 692A shall not operate, manage, be employed by, or act as a contractor or volunteer at a child care center. The sex offender also shall not be present upon the property of a child care center without the written permission of the center director, except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center.

(1) Written permission shall include the conditions under which the sex offender may be present, including:

1. The precise location in the center where the sex offender may be present;
2. The reason for the sex offender's presence at the facility;
3. The duration of the sex offender's presence;
4. Description of the supervision that the center staff will provide the sex offender to ensure that no child is alone with the sex offender.

(2) Before giving written permission, the center director shall consult with the center licensing consultant. The written permission shall be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 1209C**, IAB 12/11/13, effective 2/1/14]

441—109.11(237A) Physical facilities.

109.11(1) *Room size.* The program room size shall be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there shall be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children shall not be used as regular program space or counted as useable floor space.

109.11(2) *Infants' area.* An area shall be provided properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older. Children over 18 months of age may be grouped outside this area if appropriate to the developmental needs of the child. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is

two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

109.11(3) *Facility requirements.*

a. The center shall ensure that:

(1) The facility and premises are sanitary, safe and hazard-free.

(2) Adequate indoor and outdoor program space that is adjacent to the center is provided. Centers shall have a safe outdoor program area with at least sufficient square footage to accommodate 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area shall include safe play equipment and an area of shade.

(3) Sufficient program space is provided for dining to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures.

(4) Sufficient lighting shall be provided to allow children to adequately perform developmental tasks without eye strain.

(5) Sufficient ventilation is provided to maintain adequate indoor air quality.

(6) Sufficient heating is provided to allow children to perform tasks comfortably without excessive clothing.

(7) Sufficient cooling is provided to allow children to perform tasks without being excessively warm or subject to heat exposure.

(8) Sufficient bathroom and diapering facilities are provided to attend immediately to children's toileting needs and maintained to reduce the transmission of disease.

(9) Equipment, including kitchen appliances, placed in a program area is maintained so as not to result in burns, shock or injury to children.

(10) Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

b. Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

c. Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

d. The director or designated person shall complete and keep a record of at least monthly inspections of the outdoor recreation area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and shall complete and document an inspection prior to resuming use of the area.

e. Centers that operate in a public school building, including before and after school programs and summer programs serving school-age children, may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building. Centers shall ensure that the space occupied by the center is sanitary, safe, and hazard-free and shall conduct monthly playground inspections or provide documentation that one has been completed by the public school personnel.

109.11(4) *Bathroom facilities.* At least one functioning toilet and one sink for each 15 children shall be provided in a room with natural or artificial ventilation. Training seats or chairs may be used for children under two years of age. New construction after November 1, 1995, shall provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink shall be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

109.11(5) *Telephone.* A working nonpay telephone shall be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison information center posted adjacent to the telephone. The street address and telephone number of the center shall be included in the posting.

A separate file or listing of emergency telephone numbers for each child shall be maintained near the telephone.

109.11(6) *Kitchen appliances and microwaves.* Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area shall be sectioned off and shall not be counted as useable floor space for room size. Centers using microwave ovens for warming infant bottles or infant food shall ensure that the formula or food item is not served immediately to the child after being removed from the microwave. The infant bottle shall be shaken or food stirred and the formula or food item tested by the caregiver before being fed to the infant. Breast milk shall not be warmed in a microwave.

109.11(7) *Environmental hazards.*

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint. If the presence of peeling or chipping paint is found, interim controls using safe work methods as defined by the state department of public health shall be accomplished prior to a full license being issued.

b. Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing performed as prescribed by the state department of public health at 641—Chapter 43. Testing shall be required if test kits are available from the local health department or the Iowa Radon Coalition. Retesting shall be accomplished at least every two years from the date of the initial measurement if test kits are available from the local health department or the Iowa Radon Coalition. If testing determines confirmed radon gas levels in excess of 4.0 picocurie per liter, a plan using radon mitigation procedures established by the state department of public health shall be developed with and approved by the state department of public health prior to a full license being issued.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis prior to the heating season, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034.

d. Centers that operate before and after school programs and summer-only programs that serve only school-age children and that operate in a public school building are exempted from testing for lead, radon, and carbon monoxide.

441—109.12(237A) Activity program requirements.

109.12(1) *Activities.* The center shall have a written curriculum or program structure that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

a. A curriculum or program of activities that promotes self-esteem and positive self-image; social interaction; self-expression and communication skills; creative expression; and problem-solving skills.

b. A balance of active and quiet activities; individual and group activities; indoor and outdoor activities; and staff-initiated and child-initiated activities.

c. Activities which promote both gross and fine motor development.

d. Experiences in harmony with the ethnic and cultural backgrounds of the children.

e. A supervised nap or quiet time for all children under the age of six not enrolled in school who are present at the center for five or more hours.

109.12(2) *Discipline.* The center shall have a written policy on the discipline of children which provides for positive guidance, with direction for resolving conflict and the setting of well-defined limits.

The written policy shall be provided to staff at the start of employment and to parents at time of admission. The center shall not use as a form of discipline:

a. Corporal punishment including spanking, shaking, and slapping.

b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child. Children shall never be locked in a room, closet, box or other device. Mechanical restraints shall never be used as a form of discipline. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.

c. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) *Policies for children requiring special accommodations.* Reasonable accommodations, based on the special needs of the child, shall be made in providing care to a child with a disability. Accommodation can be a specific treatment prescribed by a professional or a parent, or a modification of equipment, or removal of physical barriers. The accommodation shall be recorded in the child's file.

109.12(4) *Play equipment, materials and furniture.* The center shall provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products. Play equipment, materials, and furniture shall meet the developmental, activity, and special needs of the children.

Rooms shall be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding shall be provided for all children who nap. The center shall develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing shall be maintained between equipment to reduce the transmission of disease, to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures. The center shall provide sufficient toilet articles for each child for hand washing. Parents may provide items for oral hygiene (if appropriate to the developmental age and needs of the child). The center shall ensure that sanitary procedures are followed for use and storage of the articles.

109.12(5) *Infant environment.* A child care center serving children two weeks to two years old must provide an environment which protects the children from physical harm, but is not so restrictive as to inhibit physical, intellectual, emotional, and social development.

a. Stimulation shall be provided to each child through being held, rocked, played with and talked with throughout the time care is provided. Insofar as possible, the same adult should provide complete care for the same child.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap which shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized by a parent or physician. A crib or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

f. When playpens are provided, no more than one child shall be placed in one at any time.

g. Infant walkers shall not be used.

h. For programs operating five hours or less on a daily basis, the center shall have a sufficient number of cribs or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products for children who may nap during the time in attendance. Cribs or criblike furniture shall be used by only one child at a time and shall be maintained in a clean and sanitary manner.

441—109.13(237A) Extended evening care. A center providing extended evening care shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.13(1) *Facility requirements.*

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene which the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

109.13(2) *Activities.*

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

441—109.14(237A) Get-well center. A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

109.14(1) *Staff requirements.*

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in state board of nursing rules at 655—6.1(152).

109.14(2) *Health policies.*

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards, approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the state department of public health.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

109.14(3) *Exceptions.* The following exceptions to 441—Chapter 109 shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over the age of two.

b. All staff that have contact with children shall have a minimum of 17 clock hours of special training in caring for mildly ill children. Current certification of the training shall be contained in the personnel files. Special training shall be department-approved and include the following:

(1) Four hours' training in infant and child cardiopulmonary resuscitation (CPR), four hours' training in pediatric first aid, and one hour of training in infection control within the first month of employment.

(2) Six hours' training in care of ill children, and two hours' training in child abuse identification and reporting within the first six months of employment and every five years thereafter.

c. There shall be 40 square feet of program space per child.

d. There shall be a sink with hot and cold running water in every child-occupied room.

e. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

f. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age, and shall be in separate rooms with full walls and doors.

441—109.15(237A) Food services. Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

109.15(1) *Nutritionally balanced meals or snacks.* The center shall serve each child a full, nutritionally balanced meal or snack as defined by the USDA Child and Adult Care Food Program (CACFP) guidelines and shall ensure that staff provide supervision at the table during snacks and meals. Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

109.15(2) *Menu planning.* The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years. Menus shall be planned at least one week in advance, made available to parents, and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children shall be avoided or modified. Provisions of this subrule notwithstanding, exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

109.15(3) *Feeding of children under two years of age.*

a. All children under 12 months of age shall be fed on demand, unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns. Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Menu patterns may be modified according to written instructions from the parent, physician or health care provider. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall

not be placed in a crib with a bottle or left sleeping with a bottle. Spoon feeding shall be adapted to the developmental capabilities of the child.

c. Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

d. Whole milk for children under age two who are not on formula or breast milk unless otherwise directed by a physician.

e. Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

109.15(4) *Food brought from home.*

a. The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines are maintained.

b. The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

c. Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

d. Snacks that may not meet CACFP nutrition guidelines may be provided by parents for special occasions such as birthdays or holidays.

109.15(5) *Food preparation, storage, and sanitation.* Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the National Health and Safety Performance Standards and provide:

a. Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

b. Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

c. Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

d. Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

109.15(6) *Water supply.* The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 110
CHILD DEVELOPMENT HOMES

[Prior to 7/1/83, Social Services[770] Ch 110]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigation.

441—110.1(237A) Definitions.

"Adult" means a person aged 18 or older.

"Assistant" means a responsible person aged 14 or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

"Child" means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

"Child care" means the care, supervision, or guidance of a child by a person other than the child's parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. Child care shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

"Child care facility" or *"facility"* means a child care center, a preschool, or a registered child development home.

"Child care home" means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

"Child development home" means a person or program registered under this chapter that may provide child care to six or more children at any one time.

"Department" means the department of human services.

"Involvement with child care" means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

"Parent" means parent or legal guardian.

"Part-time hours" means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

"Person subject to an evaluation" means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

"Provider" means the person or program that applies for registration to provide child care and is approved as a child development home.

"Registration" means the process by which child care providers certify that they comply with rules adopted by the department.

"Registration certificate" means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

"School" means kindergarten or a higher grade level.

"Transgression" means the existence of any of the following in a person's record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person's continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

441—110.2(237A) Application for registration. A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department's local office or, if available, on the department's Web site. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

441—110.3(237A) Renewal. Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, to be retained in the registration file. The renewal process shall include completion of child abuse, sex offender, and criminal record checks.

441—110.4(237A) Number of children. The number of children shall conform to the following standards:

110.4(1) *Limit.* Except as provided in subrule 110.4(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

110.4(2) *Children counted.* In determining the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

a. The child's parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

b. The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph *"a"* as though the person who established or operates the child development home is the child's parent, guardian, or custodian.

110.4(3) *Exception for emergency school closing.* On days when schools are closed due to emergencies such as inclement weather or physical plant failure, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

a. The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.

b. The child development home has a department-approved assistant, aged 14 or older, on duty to assist the care provider, as required for the registration category of the home.

c. One or more of the following conditions are applicable to each of the additional children present in the child development home:

(1) The home provides care to the child on a regular basis for periods of less than two hours.

(2) If the child were not present in the child development home, the child would be unattended.

(3) The home regularly provides care to a sibling of the child.

d. The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

441—110.5(237A) Standards. The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.8(237A), 441—110.9(237A), or 441—110.10(237A), specific to the category of home for which the provider requests registration.

110.5(1) Health and safety. Conditions in the home shall be safe, sanitary, and free of hazards.

a. The home shall have a non-pay, working telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. If the working telephone is a mobile telephone, these numbers must be programmed and saved into the telephone. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be readily accessible by the telephone. If the working telephone is a mobile telephone, these numbers must also be programmed and saved into the telephone.

b. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

c. A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

d. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children.

e. Electrical wiring shall be maintained with all accessible electrical outlets safely capped and electrical cords properly used. Improper use includes running cords under rugs, over hooks, through door openings, or other use that has been known to be hazardous.

f. Combustible materials shall be kept away from furnaces, stoves, water heaters, and gas dryers.

g. Approved safety gates at stairways and doors shall be provided and used as needed.

h. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child, and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by drainage or ponding of sewage, household waste, or storm water.

i. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

j. Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

k. Fire and tornado drills shall be practiced monthly and the provider shall keep documentation evidencing compliance with monthly practice on file.

l. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

m. The home shall have at least one 2A 10BC rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

n. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

o. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. Nonsmoking signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

(1) The telephone number for reporting complaints, and

(2) The Internet address of the department of public health (www.iowasmokefreeair.gov).

p. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

q. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that it is free of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

r. When there is a swimming or wading pool on the premises:

(1) A wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the standards of the American Society for Testing and Materials.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is four feet above the side walls.

(4) An uncovered in-ground swimming pool shall be enclosed with a fence that is at least four feet high and flush with the ground.

s. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

t. Homes served by private sewer systems shall be compliant with environmental protection commission rules on wastewater treatment and disposal systems at 567—Chapter 69. Compliance shall be verified by the local board of health within 12 months of renewal or new registration.

u. The provider shall have written policies regarding the care of mildly ill children and exclusion of children due to illness and shall inform parents of these policies.

v. The provider shall have written policy and procedures for responding to health-related emergencies.

w. The provider shall document all injuries that require first aid or medical care using an injury report form. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

x. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of peeling or chipping paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

EXCEPTION: Providers that have a valid registration on November 1, 2009, shall assess and control lead hazards by June 30, 2010.

110.5(2) Provider files. A provider file shall be maintained and shall contain the following:

a. A physical examination report. Providers and all members of a provider's household shall have good health as evidenced by a preregistration physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to registration by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

b. Certificates or other documentation from the department verifying the following:

(1) Required training as set forth in subrule 110.5(11).

(2) Completion of all record checks as required in subrule 110.7(3), at initial application, at each application for change and at each application for renewal.

c. An individual file for each staff assistant that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2)*"a."*

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

d. An individual file for each substitute that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2)*"a."*

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

(4) Certification in first aid that meets the requirements of paragraph 110.5(11)*"b."*

110.5(3) Activity program. There shall be an activity program which promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large muscle development.

d. Activities for small muscle development.

e. Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

110.5(4) The certificate of registration shall be displayed in a conspicuous place.

110.5(5) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

110.5(6) Discipline. Discipline shall conform to the following standards:

a. Corporal punishment including spanking, shaking and slapping shall not be used.

b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child shall not be used.

c. Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

e. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

110.5(7) Meals. Regular meals and midmorning and midafternoon snacks shall be provided which are well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program. Children may bring food to the child development home for their own consumption, but shall not be required to provide their own food.

110.5(8) Children's files. An individual file shall be maintained for each child and updated annually or when the provider becomes aware of changes. The file shall contain:

a. Identifying information including, at a minimum, the child's name, birth date, parent's name, address, telephone number, special needs of the child, and the parent's work address and telephone number.

b. Emergency information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

c. A signed medical consent from the parent authorizing emergency treatment.

d. An admission physical examination report signed by a licensed physician or designee in a clinic supervised by a licensed physician.

(1) The date of the physical examination shall not be more than 12 months before the child's first day of attendance at the child development home.

(2) The written report shall include past health history, status of present health, allergies and restrictive conditions, and recommendations for continued care when necessary.

(3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.

(4) The examination report or statement of health status shall be on file before the child's first day of care.

e. A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.

f. A list signed by the parent which names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

g. A signed and dated immunization certificate provided by the state department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.

h. For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

i. Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

(1) Times of departure and arrival.

(2) Destination.

(3) Persons who will be responsible for the child.

j. Injury report forms documenting injuries requiring first aid or medical care.

110.5(9) Provider. The provider shall meet the following requirements:

a. Give careful supervision at all times.

b. Exchange information with the parent of each child frequently to enhance the quality of care.

c. Give consistent, dependable care and be capable of handling emergencies.

d. Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

110.5(10) Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.

b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.

c. The substitute must be 18 years of age or older.

d. Use of a substitute shall be limited to:

(1) No more than 25 hours per month.

(2) An additional period of up to two weeks in a 12-month period.

e. The provider shall maintain a written record of the number of hours substitute care is provided, including the date and the name of the substitute.

110.5(11) Professional development.

a. The provider shall receive two hours of Iowa's training for mandatory reporting of child abuse:

(1) During the first three months of registration as a child development home; and

(2) Every five years thereafter.

b. The provider shall obtain first-aid training within the first three months of registration as a child development home.

(1) First-aid training shall be provided by a nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid) or by an equivalent trainer using curriculum approved by the department.

(2) First-aid training shall include certification in infant and child first aid that includes management of a blocked airway and mouth-to-mouth resuscitation.

(3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

c. During the first year of registration, the provider shall receive a minimum of 12 hours of training from one or more of the following content areas. The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12), and 2 of the hours must be from the content area in subparagraph 110.5(11)*"c"*(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(1) Planning a safe, healthy learning environment (includes nutrition).

(2) Steps to advance children's physical and intellectual development.

(3) Positive ways to support children's social and emotional development (includes guidance and discipline).

(4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).

(5) Strategies to manage an effective program operation (includes business practices).

(6) Maintaining a commitment to professionalism.

(7) Observing and recording children's behavior.

(8) Principles of child growth and development.

d. During the second year of registration and each succeeding year, the provider shall receive a minimum of 12 hours of training from one or more of the content areas as defined in paragraph *"c."* The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12). The provider may receive the remaining hours in self-study as defined in subrule 110.5(13). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

e. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

110.5(12) Group training. Training received in a group setting is not self-study, but is training received with other adults.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed by or obtained with the written permission of one of the following entities:

(1) An accredited university or college.

(2) A community college.

(3) Iowa State University Extension.

(4) A child care resource and referral agency.

(5) An area education agency.

(6) The regents' center for early developmental education at the University of Northern Iowa.

(7) A hospital (for health and safety, first-aid, and CPR training).

(8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).

(9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.

(10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.

(11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

(12) The Iowa department of public health, department of education, or department of human services.

(13) Head Start agencies or the Head Start technical assistance system.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph *"a"* or an entity approved under paragraph *"g."* Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

(1) The training meets the requirements in subrule 110.5(14);

(2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and

(3) The training organization meets the requirements listed in this subrule or is approved by the department.

d. The department will not approve more than eight hours of training delivered in a single day.

e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(13) Self-study training. Up to six hours of training may be received in self-study using a training package approved by the department.

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

(1) Department child care licensing consultants,

(2) Iowa State University Extension, or

(3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(14) Approved training. Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

(1) Iowa child care regulatory standards;

(2) The Iowa early learning standards; and

(3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

(1) The name of the participant.

(2) The title of the training.

(3) The dates of training.

(4) The content area addressed.

(5) The name of the training organization.

(6) The name of the instructor.

(7) The number of contact hours.

(8) An indication of whether the training was delivered through self-study or in a group setting.

[**ARC 8098B**, IAB 9/9/09, effective 11/1/09; **ARC 0666C**, IAB 4/3/13, effective 6/1/13; **ARC 0996C**, IAB 9/4/13, effective 11/1/13]

441—110.6(237A) Compliance checks. During a calendar year, the department shall check 20 percent or more of all child development homes in each county for compliance with registration requirements. Completed evaluation checklists shall be placed in the registration files.

441—110.7(234) Registration decision. The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

110.7(1) Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.7(2) Record shall be kept in an open file of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration.

110.7(3) Record checks.

a. Applicability. The department shall conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Effective July 1, 2013, registration or renewal certificates shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

b. Authorization. The person subject to record checks shall complete Form 470-5143, Iowa Department of Human Services Record Check Authorization Form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

d. National criminal history record checks. Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be effective on or after July 1, 2013, for an initial application for registration or a renewal application for registration. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the prints to the department so the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

e. Mandatory prohibition. A person with any of the following convictions or founded abuse reports is prohibited from involvement with child care:

(1) Founded child or dependent adult abuse that was determined to be sexual abuse.

(2) Placement on the sex offender registry.

(3) Felony child endangerment or neglect or abandonment of a dependent person.

(4) Felony domestic abuse.

(5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

(6) Forcible felony.

f. Mandatory time-limited prohibition.

(1) A person with the following conviction or founded abuse report is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 110.7(3)*"f"*(1), the person may request the department to perform an evaluation under paragraph 110.7(3)*"g"* to determine whether prohibition of the person's involvement with child care continues to be warranted.

g. Evaluation required. For all other transgressions, and as requested under subparagraph 110.7(3)*"f"*(2), the department shall evaluate the transgression and make a decision about the person's involvement with child care.

(1) The person with the transgression shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(2) The department may use information from the department's case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.
2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.
3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.
4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. Evaluation decision. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall mail to the person subject to an evaluation Form 470-2386, Record Check Decision, that explains the decision reached regarding the evaluation of the transgression and Form 470-4558, Notice of Decision: Child Care.

(3) The department shall issue Form 470-4558, Notice of Decision: Child Care, prohibiting involvement with child care, when the person subject to an evaluation fails to complete the Record Check Evaluation, Form 470-2310, within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

i. *Notice to parents of abuse in care.* If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care. The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in revocation of registration.

110.7(4) Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

110.7(5) If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and 441—Chapter 110, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

110.7(6) Required notifications. If a certificate of registration is revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides care. The provider shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

[**ARC 0418C**, IAB 10/31/12, effective 1/1/13; **ARC 0715C**, IAB 5/1/13, effective 7/1/13; **ARC 1209C**, IAB 12/11/13, effective 2/1/14]

441—110.8(237A) Additional requirements for child development home category A. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category A shall meet the following standards:

110.8(1) *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

110.8(2) *Provider qualifications.*

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

441—110.9(237A) Additional requirements for child development home category B. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category B shall meet the following standards:

110.9(1) *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old.

110.9(2) *Provider qualifications.*

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma or GED.

c. The provider shall either:

(1) Have two years of experience as a registered or nonregistered child care provider, or

(2) Have a child development associate credential or any two-year or four-year degree in a child-care-related field and one year of experience as a registered or nonregistered child care home provider.

110.9(3) *Facility requirements.*

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

441—110.10(237A) Additional requirements for child development home category C. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category C shall meet the following standards:

110.10(1) *Limits on number of children in care.*

a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these 12 children, not more than 4 children who are 24 months of age or younger shall be present at any one time. Whenever 4 children who are under the age of 18 months are in care, both providers shall be present.

c. In addition to the 12 children not in school, no more than 2 children who attend school may be present for a period of less than two hours at any one time.

d. In addition to these 14 children, no more than 2 children who are receiving care on a part-time basis may be present.

e. No more than 16 children shall be present at any one time when an emergency school closing is in effect. If more than 8 children are present at any one time due to an emergency school closing exception, the provider shall be assisted by a department-approved assistant who is at least 18 years of age.

f. If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

110.10(2) *Provider qualifications.*

a. One provider who meets the following qualifications must always be present:

(1) The provider shall be at least 21 years old.

(2) The provider shall have a high school diploma or GED.

(3) The provider shall either:

1. Have five years of experience as a registered or nonregistered child care provider, or

2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.

b. The coprovider shall meet the requirements of subrule 110.9(2).

110.10(3) *Facility requirements.*

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

441—110.11(237A) Complaints. The department shall conduct an on-site visit when a complaint is received.

110.11(1) After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

110.11(2) The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

441—110.12(237A) Registration actions for nonpayment of child support. The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

110.12(1) *Service of notice.* The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in

accordance with Iowa Rules of Civil Procedure 56.1. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

110.12(2) *Effective date.* The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or licensee.

110.12(3) *Preparation of notice.* The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

110.12(4) *Responsibilities of registrants and applicants.* Registrants and registrant applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

110.12(5) *District court.* A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department 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.

110.12(6) *Procedure for notification.* The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

110.12(7) *Appeal rights.* Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

441—110.13(237A) Transition exception. The following transition exceptions shall apply to providers renewing a valid previously issued child care home registration on or after December 1, 2002:

110.13(1) If the provider is providing child care to four infants at the time of renewal, the provider may continue to provide child care to those four infants. However, when the provider no longer provides child care to one or more of the four infants, or one or more of the four infants reaches the age of 24 months, this exception shall no longer apply. This exception does not affect the overall limit on the number of children in care under the child development home category within which the provider is registered.

110.13(2) If the provider is providing child care to school-age children in excess of the number allowable for the provider's registration category at the time of renewal, the provider may continue to provide care to those children and may exceed the total number of children authorized for that category by the excess number of school-age children. This exception is subject to the following conditions:

a. The maximum number of children attributable to this exception is five.

b. The provider must comply with the other requirements limiting the number of children under that registration category.

c. If more than eight children are present at any one time for more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years of age.

d. When the provider no longer provides child care to one or more of the school-age children who was receiving child care at the time of registration, the excess number of children allowed under this exception shall be reduced accordingly.

441—110.14(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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CHAPTER 111
FAMILY-LIFE HOMES

[Prior to 7/1/83, Social Services[770] Ch 111]
[Prior to 2/11/87, Human Services[498]]

441—111.1(249) Definitions.

"Department" means the Iowa department of human services.

"Eligible adult" means a person 18 years of age or older who meets the eligibility requirements for services or is a recipient of protective services, and who is considering or needs a living arrangement in a family-life home.

"Encouragement to share in the interests and activities of the household" means that the family members welcome and encourage the person to participate with them in their general family conversations and in their social, recreational, educational, and religious activities; that they invite and encourage use of the general facilities of their home; and they expect the person to care for assigned living quarters and participate within reason in the chores of the household.

"Essentially capable of self-care" means the person is ambulatory or can move from place to place; can manage the activities of daily living including personal hygiene and grooming, toileting, dressing and undressing, feeding, and medicating; and can attend to the care of personal property adequately with minimal support or occasional assistance.

"Family" means a person or persons, either related or unrelated to the client, who constitute the members of the household and are related to one another by kinship of blood, marriage, or adoption.

"Family-life home" means a private household offering a protective social living arrangement for one or two eligible adults who are not able or willing to adequately maintain themselves in an independent living arrangement, but who are essentially capable of physical self-care. In this living arrangement, the family provides the client room, board, laundry, encouragement to share in the interests and activities of the household, and opportunities for participation in the social, cultural, educational, religious, and other activities of the community.

"Not able or willing to adequately maintain themselves in an independent living arrangement" means that the person requires some assistance, encouragement, or social stimulation for adequate self-care or to maintain physical or mental health or personal safety.

"Private household" means a dwelling unit occupied exclusively by a family and furnished by and belonging to them by reason of ownership, rental, or by a contract for purchase of life estate.

441—111.2(249) Application for certification.

111.2(1) The department shall issue a certificate of approval for the operation of a family-life home upon the recommendation of a local office of the department.

111.2(2) Any person has the right to make application for a family-life home certificate.

111.2(3) Persons wishing to care for adults shall make application to the local office of the department.

111.2(4) When an applicant has reached a decision to operate a family-life home, the applicant shall complete Form 470-0606, Application for Certification.

111.2(5) Each applicant shall supply two references who may be contacted by the local office.

441—111.3(249) Provisions pertaining to the certificate.

111.3(1) No family-life home shall be certified to provide a living arrangement for more than two eligible adults.

111.3(2) At least one responsible adult member of the family shall be at the family dwelling or be reasonably available to the client, most of the daytime and nighttime hours, based on the service worker's assessment of the individual's need for supervision.

111.3(3) The certificate shall be effective for one year from date issued subject to continued compliance with rules governing the program.

111.3(4) The certificate shall not be transferred to another person nor be valid for an address other than that shown on the certificate issued.

111.3(5) A current certificate shall be in the possession of the certified family-life home, and be available for inspection.

111.3(6) There shall be no fee nor charge for certificate issued.

111.3(7) A certified family-life home shall not be concurrently licensed as a residential care facility, intermediate care facility, child care center or a foster family home. An exception may be made for a home to be concurrently licensed as a foster family home and certified as a family-life home in order to provide continued care for a person who was placed in the home as a foster child.

441—111.4(249) Physical standards.

111.4(1) The family-life home shall be safe, clean, well ventilated, properly lighted and heated. The family's dwelling shall comply with all local health ordinances.

111.4(2) The family's dwelling shall not be a dwelling unit furnished by or belonging to a client.

111.4(3) Sleeping rooms shall be suitably and comfortably furnished.

111.4(4) Each resident shall have a single bedroom unless there is agreement among the family and the residents that a room may be shared.

111.4(5) The family shall provide nutritional food, in sufficient quantity to meet the needs of the client.

441—111.5(249) Personal characteristics of family-life home family.

111.5(1) The adult head of the household shall be a mature, responsible individual who is physically able to maintain a household, and who shall exercise good judgment in caring for adults.

111.5(2) The family shall have an appreciation of and respect for the client's relationship with the client's own relatives, neighbors and friends.

111.5(3) The family shall respect the client's religious background and affiliation.

111.5(4) The family shall have sufficient income and resources to provide adequately for the family's own needs.

441—111.6(249) Health of family.

111.6(1) Prior to certification the family shall furnish the local department with a medical report on each member of the household. The report shall be on Form 470-0672, Provider Health Assessment Form.

111.6(2) The medical report shall provide significant findings of a physician, such as the presence or absence of any communicable disease.

111.6(3) Medical reexaminations may be required at the discretion of a physician or the local department.

441—111.7(249) Planned activities and personal effects.

111.7(1) The daily routine shall be to promote and provide an opportunity for normal activity with time for rest and recreation compatible with the needs of the client.

111.7(2) Every client shall be encouraged to develop social relationships through participation in neighborhood and other community and group activities.

111.7(3) The family shall not require a client to do general housecleaning, cooking, or child care for the family. A client may voluntarily share in these responsibilities.

111.7(4) Space shall be provided where a client may keep personal belongings.

441—111.8(249) Client eligibility.

111.8(1) The client shall be 18 years of age or older, as proven by birth or school records, personal records, or by records of the department or another agency.

111.8(2) The client shall be willing to live in a certified family-life home by the client's own declaration or the declaration of a person legally responsible for such client.

111.8(3) The client shall be willing to accept the terms and requirements of the family-life home program.

111.8(4) The client shall be capable of personal physical self-care.

441—111.9(249) Medical examinations, records, and care of a client.

111.9(1) A physician shall certify that the client is free from any communicable disease and does not require a higher level of care than that provided by a family-life home. The certification shall be given prior to placement and following an annual medical review thereafter. The certification shall be given on Form 470-0673, Physician's Report.

111.9(2) The family shall have available at all times, the name, address and telephone number of the client's physician.

111.9(3) The family shall keep the department informed of any health problems. The family shall immediately notify the department in case of an accident, illness, or emergency that may affect the placement.

441—111.10(249) Placement agreement. The head of the family-life home and the resident shall enter into a placement agreement by signing Form 470-0634, Placement Agreement Family-Life Home, provided by the department.

441—111.11(249) Legal liabilities. The worker shall advise the family to seek counsel regarding the family's needs for insurance to cover personal injury, property damage, and other legal contingencies.

441—111.12(249) Emergency care and release of client.

111.12(1) In case of an emergency, vacation, or overnight trip, requiring the family's temporary absence from the home, the local department shall be notified and arrangements shall be made with a designated, responsible person for the care of a client during the period of absence.

111.12(2) The department shall be notified when the client leaves or the client or family expresses a desire for the client to leave the family-life home.

441—111.13(249) Information about client to be confidential. Information concerning a client, the client's family, and the client's background shall be regarded and handled as confidential by all persons involved in the client's care.

These rules are intended to implement Iowa Code sections 234.6(6)*"e"* and 249.3(2)*"a"*(1).

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CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

[Prior to 7/1/83, Social Services[770] Ch 112]
[Prior to 2/11/87, Human Services[498]]

441—112.1(237) Applicability. This chapter relates to licensing procedures for all child foster care facilities authorized by Iowa Code chapter 237. Rules relating to specific types of facilities are located in 441—Chapter 113, "Licensing and Regulation of Foster Family Homes," 441—Chapter 114, "Licensing and Regulation of All Group Living Foster Care Facilities for Children," 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Mentally Retarded Children."

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.2(237) Definitions.

"Applicant:"

1. The applicant for a foster family home license is the foster parent or parents.
2. For a proprietary child caring facility, the applicant is the owner of the facility.
3. For facilities having a board of directors, the applicant may be the president of the board or the board's designee.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Comprehensive residential facility" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual treatment plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, mechanical restraints, and chemical restraints when these controls meet licensing requirements.

"Director's designee:"

1. For group facilities, the director's designee is the chief of the bureau of protective services.
2. For foster family homes, the designee is the department of human services' service area manager.

"Foster family home" means a home in which an individual person or married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

"Group facility" means a community residential facility, a comprehensive residential facility, or a residential facility for mentally retarded children.

"Residential facility for mentally retarded children" means any residential facility which serves children who meet the definition of mentally retarded as defined in Iowa Code chapter 222.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

441—112.3(237) Application for license.

112.3(1) *Right to apply.* Any adult individual or agency has the right to apply for a license.

a. *Foster family care.* A person wishing to apply to be a foster parent shall contact the department's recruitment and retention contractor at 1-800-243-0756 to request an application packet. This procedure also applies to:

(1) Persons wishing to care for children placed through any public or private agency.

(2) A relative who is caring for a child directly placed by the child's parents, guardians, or another relative and who wishes to be licensed as a foster parent.

b. *Group care.* A person wishing to apply for a group care license shall contact the department:

(1) Through the "Child Welfare" link on the department's Web site, www.dhs.iowa.gov; or

(2) By mail to the DHS Division of Child and Family Services, Attn: Group Care Licensing, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

112.3(2) *Decision to operate a facility.*

a. When an applicant has reached a decision to operate a foster family home, the applicant shall complete Form 470-0689, Foster Family Home License Application.

b. When an applicant has reached a decision to operate a group facility, the applicant shall complete Form 470-0723, Application for License or Certificate of Approval.

112.3(3) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

112.3(4) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded abuse report on a director, a sole proprietor involved in the facility's operation, or any facility staff shall be evaluated by the department to determine if the abuse merits prohibition of employment or licensure.

b. The department shall evaluate all founded child abuse on a case-by-case basis. Considerations shall include, but not be limited to:

(1) The facility's response (e.g., immediate termination of involved staff).

(2) Whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

112.3(5) *Reports and information.* Requested reports and information relevant to the licensing determination shall be furnished to the department by the applicant.

112.3(6) *Applications for renewal.*

a. The department or its agent shall send the licensee an application for renewal 90 days before the license expires. Applications for license renewal shall be made on the form specified in subrule 112.3(2).

b. Applications for renewal shall be made at least 30 but no more than 90 days before the license expires. Applications for renewal of a group care license shall be submitted to the address in subparagraph 112.3(1)*"b"*(2). Applications for renewal of a foster family home license shall be submitted to the recruitment and retention contractor.

c. The department shall approve or deny an application for license renewal through the same process as that used for the original application.

112.3(7) *Notification.*

a. *Foster family homes.*

(1) The department shall notify an applicant of the approval or denial of an initial license within 140 days of the date that the applicant begins the preservice training required in 441—subrule 113.8(1). When preservice training is waived, the department shall notify the applicant of approval or denial within 120 days of the date that the training waiver is granted.

(2) The department shall notify a licensee of the approval or denial of license renewal within 90 days of reapplication.

b. *Group facilities.* The department shall notify a group facility of approval or denial of a license within 90 days of application or reapplication.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.4(237) License.

112.4(1) A new license shall be obtained when the licensee moves or the facility is remodeled.

112.4(2) A new license shall be requested when the facility wishes to be licensed for a different number of children.

112.4(3) When corrective action is completed on or before the date specified on a provisional license, a full license shall be issued for the remainder of the licensure term.

112.4(4) When the corrective action is not completed by the date specified on a provisional license, a full license shall be denied.

112.4(5) The department shall issue Form 470-0727, Certificate of License, without cost to any foster family that meets the standards. The department shall issue Form 470-3623, Certificate of License, without cost to any group facility that meets the standards. The department may offer consultation to assist applicants in meeting the standards.

112.4(6) A foster family license shall be approved for a term of one year for the first and second years of licensure. Thereafter, the license shall be approved for a term of two years unless it is determined by the administrator that a one-year license may be issued. A group facility license shall be approved for a term of one to three years according to the following criteria:

a. A one-year license may be approved for all new agencies that meet licensure standards.

b. A two-year license may be approved upon completion of a survey for a renewal license when:

(1) Some health or safety concerns have been identified, but they are determined to be minor or easily corrected;

(2) Some complaints against a facility have been substantiated, but they are determined to be minor; and

(3) Deficiencies that have been identified are determined to be minor or easily corrected.

c. A three-year license may be approved upon completion of a survey for a renewal license when:

(1) No health or safety deficiencies have been identified;

(2) There have either been no substantiated complaints against the facility or, if substantiated, complaints have been determined not to be serious or severe; and

(3) A facility has no founded incidents of child abuse by facility staff.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 0356C**, IAB 10/3/12, effective 12/1/12]

441—112.5(237) Denial.

112.5(1) The department shall deny the license application when:

a. The minimum standards set forth in these rules are not met and a provisional license is inappropriate or disapproved by the director's designee.

b. For just cause.

c. The applicant, as a sole proprietor or a foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. The applicant, as a sole proprietor or foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has a record of founded child abuse unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. The application is fraudulent, which means that the applicant has knowingly made fraudulent statements or has knowingly concealed information.

112.5(2) Reapplications shall be denied:

a. For the same reasons as original applications.

b. For the same reasons as listed in the grounds for revocation.

c. When the foster family applicant's license has been denied or revoked within the 12 months before the date of reapplication. Denial for this reason does not require a licensing study.

d. If the foster family refuses to engage as a resource to a foster child's birth parents when engagement can be done in a way that does not put the foster family or the foster child at risk of harm.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.6(237) Revocation.

112.6(1) *Mandatory.* The department shall revoke the license for the following reasons unless subrule 112.6(3) applies:

a. When the facility is misusing funds furnished by the department.

b. When the facility is operating without due regard to the health, sanitation, hygiene, comfort, or well-being of the children in the facility.

c. When the director or sole proprietor involved in the operation of the facility, or foster parent, or any person residing in the foster home other than a foster child, or any facility staff has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. When there is a founded abuse report on a foster family home parent, any person residing in a foster family home other than a foster child, a director or sole proprietor who is involved in the facility's operation, or any facility staff, unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. Rescinded, effective November 1, 1987.

112.6(2) *Optional.* Licenses may be revoked for any of the following reasons unless subrule 112.6(3) applies:

a. The foster family fails to notify the licensing worker when moving to a new home within 30 days after the date of moving.

b. Rescinded, effective July 1, 1987.

c. The foster family or facility fails to meet any or all requirements of the placement agreement.

d. Rescinded, effective July 1, 1987.

e. Rescinded, effective July 1, 1987.

f. The child foster care facility fails to continue to comply with all of the licensing requirements in both law and regulation.

g. The foster family or the staff of a licensed group facility refuses to cooperate with an unannounced visit.

112.6(3) *Exceptions.* The license for a foster family home shall not be revoked when there are 30 or fewer days until the date the license expires.

The foster family home shall be advised in writing that a reapplication may be denied and the reasons for the possible denial. The foster family home license may be suspended immediately pursuant to rule 441—112.9(237).

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

441—112.7(237) Provisional license.

112.7(1) *Statement of reasons for provisional licenses.* Provisional licenses shall be accompanied by a statement of the reasons for the provisional license, the standards that have not been met, the date that the facility must make required changes to meet standards.

112.7(2) *Corrective action.* The facility shall furnish the licensing agency with a plan of action to correct deficiencies listed that resulted in the provisional license. The plan shall give specific dates upon which the corrective action will be completed.

This rule is intended to implement Iowa Code section 237.5.

441—112.8(237) Adverse actions. Notice of adverse actions and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7. Any issues of placement or payment are independent of the licensing decision and right of appeal.

This rule is intended to implement Iowa Code section 237.5.

441—112.9(237) Suspension.

112.9(1) *Types of suspension.* There are two types of suspension of a license.

a. Emergency suspensions are to prevent persons from providing foster care by suspending their license until it is revoked or denied.

b. Time-limited suspensions are to prevent persons from providing foster care by suspending their license until a deficiency in the home or facility is corrected.

112.9(2) *Requirements for emergency suspension.* The emergency suspension of a license by the director or designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. There are sufficient grounds for revocation on denial of the license.

c. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

d. The existence of the condition requiring suspension is documented in the licensee's record.

112.9(3) *Requirements for time-limited suspensions.* The time-limited suspension of a license by the director or designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

c. The existence of the condition requiring suspension is documented in the licensee's record.

d. The condition requiring the suspension can be corrected by the licensee to meet licensing requirements.

e. If the condition were corrected, a full license would be issued.

f. The licensee signs a written statement acknowledging the existence of the condition, citing the law or rule violated, and making a commitment to correct the condition within a specific time period, not to exceed the period of the license.

112.9(4) *Effective period of suspensions.* A suspension shall be effective on the date the notice is received by the licensee and shall remain in effect until one of the following occurs:

a. The department withdraws the suspension due to a change in conditions in the home or facility.

b. The court orders the license reinstated.

c. The action is reversed by a final decision in accordance with 441—Chapter 7.

d. For emergency suspensions, a revocation or denial becomes effective and the license is rescinded.

e. The licensing period expires.

f. For time-limited suspensions, the period of suspension ends.

112.9(5) *Method and content of notice.* The notice of suspension shall be sent by restricted certified mail or personal service and shall include the following:

a. The condition requiring the suspension.

b. The specific law or rule violated.

c. The type of suspension.

d. For an emergency suspension, the adverse action being sought by the department.

e. For a time-limited suspension, the duration of the suspension.

112.9(6) *Right to appeal suspension.* The licensee has the right to appeal the suspension of the license, but initiation of an appeal does not alter the suspension.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.10(232) Mandatory reporting of child abuse.

112.10(1) *Mandatory reporters.* The following foster care providers shall make a report, in accordance with Iowa Code section 232.69, whenever they reasonably believe a child for whom they are providing foster care has suffered abuse:

a. Any social worker who is employed by a licensed child foster care facility and who works with foster children.

b. Any licensed foster parent providing child foster care.

112.10(2) *Required training.* Within one year of becoming a mandatory reporter, and every five years thereafter, any person required to make a report under subrule 112.10(1) shall complete two hours of training relating to the identification and reporting of child abuse.

112.10(3) *Training provider.*

a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall be responsible for providing the required training in child abuse identification and reporting.

b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for obtaining the required two-hour training in child abuse identification and reporting as part of a continuing education program required under Iowa Code section 232.69 and chapter 272C and approved by the department of public health.

112.10(4) *Training content.*

a. Training in child abuse identification shall include physical and behavioral signs of physical abuse, denial of critical care and sexual abuse.

b. Training in child abuse reporting shall include reporting requirements and procedures.

112.10(5) *Training documentation.*

a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall document in the employee's personnel record the content and amount of training.

b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for securing documentation of the training content, amount, and provider, and shall forward the documentation to the department's recruitment and retention contractor, which will provide a copy to the department licensing worker for the service area where the family resides for inclusion in the licensing file.

This rule is intended to implement Iowa Code section 232.69.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

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CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

[Prior to 7/1/83, Social Services [770] Ch 113]
[Prior to 2/11/87, Human Services[498]]

441—113.1(237) Applicability. This chapter specifically relates to the licensing and regulation of foster family homes. Refer to 441—Chapter 112 for general licensing rules and regulations which apply to all foster care facilities, including foster family homes.

This rule is intended to implement Iowa Code chapter 237.

441—113.2(237) Definitions.

"Corporal punishment" means the intentional physical punishment of a foster child.

"Department" means the Iowa department of human services.

"Foster family home" means an individual person or married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

"Reasonable force" means that force, and no more, which a reasonable person in like circumstances would judge to be necessary to prevent an injury or loss.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

"Service area manager" means the department employee responsible for managing department offices within a department service area.

"Social work administrator" means the department employee responsible for supervising the social work staff within a department service area and for implementing service policies and procedures of the department.

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.3(237) Licensing procedure.

113.3(1) *Application.* Applications for an initial license to operate a foster family home shall be submitted and processed as directed in rule 441—112.3(237). In addition to the application form, the applicant shall submit the following:

a. Form 595-1396, DHS Criminal History Record Check, for each person living in the home who is 14 years of age or older, as required by rule 441—113.13(237).

b. Form 470-0720, Physician's Report for Foster and Adoptive Parents, to satisfy the requirements of rule 441—113.11(237).

c. Form 470-3226, HIV General Agreement, to indicate choices about caring for children who have or are at risk for HIV infection.

d. Form 470-0693, Foster Care Private Water Supply Survey, if applicable.

e. A drawing of the floor plan of the family's home.

f. If licensed to drive, a copy of the driver's license and motor vehicle insurance.

113.3(2) *Orientation.* Applicants shall attend an orientation provided by the recruitment and retention contractor as described in rule 441—117.2(237).

113.3(3) *Record checks.* Before beginning preservice training, applicants shall pass at least the local record check procedures as specified in rule 441—113.13(237).

113.3(4) *Home study.* The worker for the recruitment and retention contractor shall complete a family home study.

a. *Process.* Information for the home study is gathered primarily through the required preservice training as described in rule 441—117.1(237). In addition:

(1) The worker shall hold at least two face-to-face interviews with the applicant.

(2) The worker shall hold at least one face-to-face interview with each member of the household.

(3) At least one of the interviews shall take place at the applicant's home. A physical inspection of the home is required to verify compliance with the standards in this chapter.

(4) Reference checks shall be conducted as described at rule 441—113.14(237).

b. *Family assessment topics.* The assessment of the prospective foster family shall evaluate the family's ability to parent a special needs child. The assessment shall include the following:

(1) The applicant's motivation for foster care and whether the family has biological, adopted, or foster children.

(2) The attitude of the family and the extended family toward accepting a foster child.

(3) The applicant's emotional stability; marital relationship and history, including verification of marriages and divorces; family relationships; and compatibility.

(4) The applicant's ability to cope with problems, stress, frustrations, crisis, separation, and loss.

(5) Medical, mental, and emotional conditions that may affect the applicant's ability to parent a child; treatment history; current status of treatment; and the evaluation of the treatment.

(6) The applicant's willingness to accept a child who has medical problems (such as HIV), mental retardation, or emotional or behavioral problems.

(7) The applicant's ability to provide for a child's physical, medical, and emotional needs and respect the child's ethnic and religious identity.

(8) The safety of foster children in relation to any animals that live on the applicant's property.

(9) The adjustment of any children in the home, including their attitudes toward foster care and adoption, relationships with others, and school performance.

(10) An assessment of the applicant's disciplinary techniques and practices.

(11) The applicant's financial information and ability to provide for a child.

(12) The applicant's attitude toward the foster child's birth parents and siblings.

(13) The applicant's commitment to and capacity to maintain a foster child's significant relationships and work with the child's parents when the permanency goal is reunification.

(14) Any history of substance use or substance abuse by family members or members of the household, including treatment history and current status of treatment.

(15) Any history of abuse by family members or members of the household, including treatment history, current status of treatment, and how this issue would affect the applicant's ability to be a foster parent.

(16) Any criminal convictions of family members or adults in the household and the evaluation of the criminal record.

c. *Written report.* The recruitment and retention contractor shall prepare a written report of the family assessment using Form 470-4029, PS-MAPP Family Profile Summary, and RC-0025, Home Study Summary and Recommendation Outline. The summary shall include a recommendation for the number, age, sex, characteristics, and special needs of a child or children the family can best parent, and any other pertinent information in making the licensing recommendation. The home study shall be maintained in the foster family record.

113.3(5) *Decision.* The department worker shall use the home study to approve or deny a prospective family as an appropriate placement for a child or children. The department worker shall notify the family of the licensing decision using Form 470-0709, Notice of Action: Foster Family Home.

a. Upon approval, the department shall issue the applicant a license as described at rule 441—112.4(237) to care for the number of foster children allowed under subrule 113.4(1).

b. If the department worker does not approve the home study, the notice shall state the reasons for that decision, as listed in rule 441—112.5(237). A license denial may be appealed as described at rule 441—112.8(237).

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.4(237) Provisions pertaining to the license. On a case-by-case basis, the service area manager or area social work administrator may waive any standard in this chapter unless:

1. The requirement is set in state or federal law; or

2. The waiver could have a negative impact on the safety and well-being of a child placed in the foster family home.

113.4(1) *Number of children.* A foster family home may care for up to five children unless a variance is approved as described in this rule. The license capacity shall be based on the number of the foster family's biological and adoptive children and any relative placements. The license shall be issued for at least one child. A child who has reached the age of 18 and remains eligible for foster family care shall be included in the license capacity. Any variance to this rule must:

a. Be approved by the service area manager or designee.

b. Be documented in the licensing record with reasons given for granting the variance.

c. Meet one of the following criteria:

(1) A variance is necessary to keep a sibling group together. No variance shall be granted if the foster home is at licensed capacity and there are no members of the sibling group in the foster home.

(2) The foster parents have three or more children in the home and have shown the ability to parent a large number of children. A variance may be approved to allow the placement of up to three foster children as set forth in the chart below:

No. of Children in the Home (birth/relative/adoptive placements)	Maximum License Capacity:	
	Without variance	With variance
0 children	5	Not applicable
1 child	4	Not applicable
2 children	3	Not applicable
3 children	2	3
4 children	1	3
5 or more children	Not applicable	3

(3) A variance beyond the maximum capacity of the foster home license is needed for the placement of a specific child in foster family care. A child-specific variance shall end when that child leaves the placement or any other change brings the family into licensed capacity.

d. All other licensing requirements including, but not limited to, parenting ability and available bedroom space must be met before a foster home can be approved for a variance.

113.4(2) *Employees of the department as foster parents.* Employees of the department may be licensed as foster family home parents unless they are engaged in the administration or provision of foster care services. Employees engaged in the administration or provision of foster care services include:

a. Child care staff, social workers, youth service workers or their supervisors involved in programs for children in state institutions.

b. Foster care service workers, foster care licensing staff, and their supervisors employed in county or central offices of the department.

c. Other staff engaged in foster care placements, such as child protective staff or adoption workers.

d. Department staff responsible for the development of policies and procedures relating to foster care licensing and placement.

113.4(3) *Limits on foster family home licensure.* A licensed foster family home shall not be permitted to be a licensed comprehensive residential facility, community residential facility, or licensed child care center.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.5(237) Physical standards.

113.5(1) *General standards.* The foster home shall be safe, clean, well ventilated, properly lighted, properly heated, and free from vermin and rodents to ensure the well-being of the foster children residing in the home.

113.5(2) *Grounds.*

a. There shall be safe outdoor space provided according to the age and developmental needs of the foster child for active play. The area available shall be documented in the case record.

b. The foster child shall be protected against hazards including, but not limited to, traffic, pools, railroads, waste material, and contaminated water.

113.5(3) *Bedrooms for foster children.*

a. Bedrooms shall either have been constructed for the purpose of providing sleeping accommodation or remodeled for sleeping to provide proper heat and ventilation. Bedroom additions to a home shall meet building code requirements. All bedrooms used by foster children must have:

(1) Permanent walls;

(2) A door that closes;

(3) An unobstructed, operable window that opens from the inside;

(4) A closet, wardrobe, armoire, or dresser; and

(5) A standard bed, or a crib for infants and toddlers who cannot safely use a standard bed.

b. The minimum bedroom area per child shall be 40 square feet. However, the service area manager or designee may approve a smaller room size when approval is in the best interest of specific children placed or to be placed in the home. Such approvals shall:

(1) Be in writing;

(2) Contain the names and birth dates of the children for whom issued; and

(3) Be reviewed at each license renewal.

c. When bedrooms meet only minimum requirements, the home shall provide additional room in other parts of the home for study and play.

d. The ceiling height for bedrooms shall be adequate for the child.

e. Bedrooms belowground shall:

(1) Be free from excessive dampness, noxious gases, and objectionable odors;

(2) Have access to at least one direct exit to the outside from the level belowground and one inside stairway exit from the level belowground;

(3) Have an egress window with a clear opening area with an opening height of 24 inches and an opening width of 20 inches or an opening height of 20 inches and an opening width of 24 inches;

(4) Have provisions, such as a ladder or steps, to ensure that the foster child can safely reach the window if the finished sill height is more than 44 inches above the floor and that the foster child can safely reach ground level if there is a window well that has a depth of 44 inches or higher;

(5) Have a finished ceiling; and

(6) Have a covered floor.

113.5(4) *All rooms aboveground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(5) *Rooms belowground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(6) *Physical care standards for foster children.*

a. Grouping children in bedrooms shall take into consideration the age and sex of children.

(1) Children over 6 years of age shall not share a bedroom with a child of the opposite sex.

(2) Foster children over the age of 2 shall not share a bedroom with any person over the age of 18 in the home unless approved by the social work administrator or designee.

(3) Foster children shall not share a bed with any other child.

b. Foster parents shall have a designated bedroom. Children 2 years of age or older shall be provided bedroom space other than in the foster parents' bedroom. Foster children under the age of 2 may share a bedroom with the foster parent.

c. There shall be provisions for isolating from other children, a child who is ill or suspected of having a contagious disease.

d. The foster home shall provide food with good nutritional content and in sufficient quantity to meet the individual needs of the children.

e. Linens shall be changed at least weekly and more frequently for children with bladder or bowel control problems.

f. Waterproof mattress covers shall be provided for children under three years of age and for any child who lacks bowel or bladder control.

g. Individual space shall be provided for the child's clothes and personal possessions.

h. Foster parents shall follow universal precautions to reduce exposure to bloodborne pathogens and other infectious materials when providing care to all children placed in their physical custody.

i. Children under the age of 1 year shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

j. Smoking shall be prohibited in the foster home or any vehicle when the foster child is present.

113.5(7) *Lead-based paint.* If the applicant lives in a home built before 1960, the applicant shall submit Form 470-4819, Lead Paint Assessment, certifying that the applicant:

a. Has conducted a visual assessment for lead hazards that exist in the form of peeling or chipping paint; and

b. Has applied interim controls using safe work methods if the presence of peeling or chipping paint is found, unless an inspector certified pursuant to department of public health rules at 641—Chapter 70 has determined that the paint is not lead-based. "Interim controls" are measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, such as repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, and temporary containment.

113.5(8) *Artificial lighting.* Adequate artificial lighting fixtures shall be provided for study in areas where children will be studying.

113.5(9) *Toilet facilities.*

a. Toilet facilities shall have natural or artificial ventilation.

b. All toilet facilities shall be maintained in a clean and working condition.

113.5(10) *Heating plant.*

a. The heating plant shall have a capacity to maintain a temperature of approximately 65 degrees Fahrenheit:

(1) At a point 24 inches from the floor during the day in severe weather, and

(2) In the bedrooms with the door closed.

b. Fireplaces and water heaters shall be vented to the outside atmosphere. Kerosene heaters and gas-fired space heaters shall not be used to heat any space in the home.

113.5(11) *Ventilation.* Ventilation shall be provided in all rooms where foster children eat, sleep, and play either by windows which can be opened or by mechanical venting systems. Windows and doors used for ventilation shall be screened.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12]

441—113.6(237) Sanitation, water, and waste disposal.

113.6(1) *Food preparation and storage.* Food preparation areas shall be clean and there shall be facilities to store perishable food at cold temperatures and storage areas for other food supplies.

113.6(2) *Milk supply.* Fluid or powdered milk sufficient to meet the needs of the foster child shall be provided.

113.6(3) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

113.6(4) *Private water supply.*

a. Each privately operated water supply shall be annually checked and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples must be collected and submitted by the licensing worker or health sanitarian to the university hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria. In order to be licensed for the care of children under two years of age the nitrate (NO^3) content must be analyzed.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When the water sample result shows the water is potable, the license can be granted.

e. When the water sample is not approved, no license shall be issued until the foster parents provide a written statement that foster children will be provided potable water, where it will be obtained, and how it will be transported and stored.

(1) The statement shall be provided on Form 470-0699, Provisions for Alternate Water Supply.

(2) Annual testing of the water may be waived after three consecutive years when the family has made ongoing alternative arrangements for the use of safe, potable water.

113.6(5) *Sewage treatment.*

a. Foster homes, wherever possible, shall be connected to public sewer systems.

b. Private disposal systems shall be designed, constructed and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

113.6(6) *Garbage storage and disposal.*

a. A sufficient number of covered garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, watertight, and rodent proof and shall be maintained in a sanitary condition.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.7(237) Safety.

113.7(1) *Fire protection for bedrooms.* Any floor of a house, including the basement, used for the sleeping of foster children shall be equipped with the following:

a. A working smoke detector in a location where sleeping areas can be alerted. For hearing-impaired children, the foster parent shall install a smoke detector in the child's bedroom that will use an alternative means of waking the child.

b. Hallways and stairways free of debris and clutter to allow unrestricted access to an exit.

c. A working carbon monoxide detector in all homes with:

(1) Gas appliances, furnaces, fireplaces, or other gas equipment; and

(2) Attached garages.

113.7(2) *Combustion hazards.*

a. Combustible materials shall be kept away from heat sources, including but not limited to furnaces, stoves, electrical panels, space heaters, and hot water heaters.

b. Explosives and flammable substances shall be stored securely and be inaccessible to a child. Matches and lighters shall be inaccessible to a child.

c. The home shall have at least one operable 2A-10BC-rated or ABC-rated fire extinguisher.

113.7(3) *Safety plan.* The family shall have an emergency safety plan to be used in case of fire, tornado, blizzard, flood, other natural or manmade disasters, accidents, medical issues, and other life-threatening situations for children in out-of-home placements.

a. Safety plans for fire and tornadoes shall be documented and reviewed with foster children at the time of placement and practiced with the foster children throughout the year.

b. In the case of a disaster requiring evacuation of the home, the foster parents shall notify the department of the address and telephone number of the parents' temporary residence within 48 hours.

c. The plans shall include a designated meeting place.

113.7(4) *Medications and poisonous substances.* All prescription medications and poisonous substances shall be kept in a locked storage container out of the reach of children.

a. All prescription medication shall be administered as prescribed and documented in a prescription medication log.

b. All over-the-counter medications shall be administered according to label directions or as directed by a physician.

113.7(5) *Weapons.* All weapons, firearms, and ammunition shall be inaccessible to a child of any age.

a. Weapons and firearms shall be maintained in a locked place, such as a gun case.

b. Ammunition shall be maintained in a locked place separate from the firearms.

c. Any motor vehicles used to transport foster children shall not contain a loaded gun, and any ammunition in the vehicle shall be kept in a separate, locked container.

d. Foster parents who have a permit to carry a firearm shall sign Form 470-4657, Firearms Safety Plan.

113.7(6) *Transporting foster children.*

a. Foster parents shall have a valid Iowa driver's license and adequate motor vehicle insurance when the foster parents transport foster children in a motor vehicle.

b. Foster parents shall ensure that appropriate child safety restraints, as required by Iowa law, are used for all foster children when the foster parents transport the children in a motor vehicle.

c. Any motor vehicles used to transport foster children shall be smoke-free when foster children are being transported.

113.7(7) *Supervision.* The foster parents shall provide reasonable supervision of foster children to ensure their safety.

a. Foster parents shall monitor foster children while the children are using hazardous items. All dangerous objects or equipment, including but not limited to trampolines, motorized vehicles, and power tools, shall be inaccessible to a child unless:

(1) There is reasonable supervision by the foster parent, and

(2) Permission has been obtained from the parent or guardian for the foster child to use the equipment or vehicle.

b. Foster parents shall monitor foster children while they are using the Internet.

113.7(8) *Household pets.* Household pets and any outdoor animals or pets accessible to foster children shall have a current veterinary health certificate verifying that the animal has had routine vaccinations that are required by local ordinance.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12]

441—113.8(237) Foster parent training.

113.8(1) *Preservice training.* All foster parent applicants shall complete the following training before licensure and the placement of a child in foster care in their home:

a. Orientation pursuant to rule 441—117.2(237); and

b. Preservice training pursuant to rule 441—117.1(237).

113.8(2) *In-service training.* All licensed foster parents shall complete six hours of in-service training annually as required by rule 441—117.7(237).

a. All foster parents shall complete training in medication management, cardiopulmonary resuscitation, and first aid in their first year of licensure as required by rule 441—117.8(237).

b. All licensed foster parents shall complete training on child abuse identification and reporting in their first year of licensure and every five years thereafter as required by rule 441—112.10(232) and 441—subrule 117.8(4).

This rule is intended to implement Iowa Code section 237.5A.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.9(237) Involvement of kin.

113.9(1) *Support by foster parents.* Foster parents shall support the involvement of biological or adoptive parents and other relatives of the foster child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

113.9(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the foster parents, biological or adoptive parents, and others involved with the child and family.

113.9(3) *Cultural connections.* Throughout the provision of care, the foster family shall actively ensure that the foster child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.10(237) Information on the foster child.

113.10(1) *Initial information.* Rescinded IAB 7/29/09, effective 10/1/09.

113.10(2) *Foster child information.* Foster parents shall maintain a separate folder of information on each foster child placed in the foster family home. This folder shall be provided to the department or the child's parent or guardian when the child leaves the placement. The folder shall contain:

a. Names and addresses of all doctors, mental health professionals, and dentists who have treated the child and the type of treatment received while in the foster home.

b. School reports including report cards and pictures.

c. Date the child left the placement.

d. Name, address, and telephone number of the person to whom the child is discharged.

113.10(3) *Confidentiality.* Foster parents shall maintain confidentiality regarding a child in placement except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Foster parents shall not post pictures or information concerning a foster child on any Internet Web site.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.11(237) Health of foster family.

113.11(1) *Health report required.* The foster parents shall furnish the licensing agency with a health report on the family completed no more than six months before the application for licensure. The report shall include information on all family members. An updated report shall be provided upon request of the department licensing worker or the recruitment and retention contractor.

113.11(2) *Contents of report.* This report shall include a statement from the health practitioner that there are no physical or mental health problems which would be a hazard to foster children placed in the home and a statement that the foster parents' health would not prevent needed care from being provided to the child.

113.11(3) *Capability for caring for the child.* If there is evidence that the foster parent is unable to provide necessary care for the child, the department licensing worker, the recruitment and retention contractor, or the physician may require additional medical and mental health reports.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.12(237) Characteristics of foster parents.

113.12(1) *Age.*

a. Foster parents shall be at least 21 years of age.

b. The age of foster parents shall be considered as it affects their ability to care for a specific child and function in a parental role.

113.12(2) *Income and resources.* The foster family shall have sufficient income and resources to provide adequately for the family's own needs.

113.12(3) *Religious considerations.* The foster parent shall respect the foster child's religious background and affiliation.

113.12(4) *Requirements of foster parents.* Foster parents shall be stable, responsible, physically able to care for the type of child placed, mature individuals who are not unsuited by reason of substance abuse, lewd or lascivious behavior or other conduct likely to be detrimental to the physical or mental health or morals of the child. They shall exercise good judgment in caring for children and have a capacity to accept agency supervision.

113.12(5) *Personal characteristics.* The foster parents shall:

a. Provide evidence of marital adjustment and stability.

b. Have realistic expectations of foster children.

c. Have time available to parent foster children.

d. Be able to accept and deal with acting out behavior with realistic expectations and good judgment.

e. Include foster children in normal family life.

f. Have the ability to be accepting and loving toward a foster child entering the home.

g. Be able to support the case permanency plan for the foster child and be willing to cooperate with visits, transportation, or other activities that support the child's connection to and reunification with the child's family.

h. Ensure that all family members are aware of and in agreement with having foster children in the home.

113.12(6) *Determination of characteristics.* The areas discussed in 113.12(4) and 113.12(5) shall be explored through observation of the family and interviews with family members and documented in a foster home study as described in subrule 113.3(4). Any additional areas that the family or worker identifies as a possibility for creating problems shall also be documented in the foster family record.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.13(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 14 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse reports or criminal convictions or has been placed on the sex offender registry.

113.13(1) *Procedure.* The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting.

a. *Iowa records.* Each foster parent applicant and anyone who is 14 years of age or older living in the home of the applicant shall be checked for records with:

(1) The Iowa central abuse registry, using Form 470-0643, Request for Child Abuse Information;

(2) The Iowa division of criminal investigation, using Form 595-1396, DHS Criminal History Record Check, Form B; and

(3) The Iowa sex offender registry.

b. *Other records.*

(1) Each foster parent applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years.

(2) Each foster parent applicant shall also be fingerprinted for a national criminal history check. Other adults living in the home may be fingerprinted if the department determines that a national criminal history check is warranted.

113.13(2) *Evaluation of record.* If the applicant or anyone living in the home has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the department shall not license the applicant as a foster family unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of license.

a. *Exclusion.* An evaluation shall not be performed if the person has been convicted of:

(1) A felony offense as set forth in Iowa Code section 237.8(2)*"a"*(4); or

(2) A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)*"a"*(4) if the crime were committed in Iowa.

b. *Scope.* The evaluation shall consider the nature and seriousness of the founded child abuse or crime in relation to:

(1) The position sought or held,

(2) The time elapsed since the abuse or crime was committed,

(3) The degree of rehabilitation,

(4) The likelihood that the person will commit the abuse or crime again, and

(5) The number of abuses or crimes committed by the person.

c. *Evaluation form.* The person with the founded child abuse or criminal conviction report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date of receipt to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of licensure.

113.13(3) *Evaluation decision.* The service area manager or designee shall conduct the evaluation and make the decision. The department shall issue Form 470-2386, Record Check Decision, to explain the decision reached regarding the evaluation of an abuse or a crime. The department shall mail the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed Form 470-2310, Record Check Evaluation, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified in paragraph 113.13(2)*"c."*

113.13(4) *License renewal.* Foster parents applying for an annual or biennial license renewal shall be subject to the same checks as new applicants, except for fingerprinting. The department shall evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation shall be conducted using the same process.

This rule is intended to implement Iowa Code section 237.8(2).

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12]

441—113.14(237) Reference checks.

113.14(1) At least three additional unsolicited references shall be checked for all foster family home applicants in addition to a minimum of three references provided by the applicant.

113.14(2) Responses of references shall be documented in the applicant's record.

113.14(3) Information received from references may be discussed with the applicant at the discretion of the worker. The reference shall be so informed.

113.14(4) Reference checks shall include only those areas related to the applicant's ability to care for children and should include discussion of the following areas:

a. How long and in what capacity the reference has known the applicant.

b. Personal qualities of the applicant including the general character, ability to get along with others, ability to deal with children's problem behavior, ability to give affection and care, discussion of use of drugs and alcohol, questions regarding personal difficulties that could be detrimental to a foster child.

c. Marital adjustment and stability.

d. How the applicant handles anger, problems, crisis situations, discipline, and disappointments.

e. Any areas of general concern not previously mentioned.

f. Would the reference feel comfortable leaving a child in this home for a period of time?

g. Recommendations regarding licensing.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.15(237) Unannounced visits.

113.15(1) The department's recruitment and retention contractor shall make unannounced visits during periods of the day when the child and foster parents would normally be at home and awake, unless there has been a specific complaint about the family and care of the child.

113.15(2) The unannounced visit shall include, but is not limited to, assessment of the following areas:

a. Home environment.

b. Who was present at the time of the visit.

c. Interaction between the foster child and foster family and their children.

d. The foster child's perception of the foster parents, other children and adults in the home, behavioral expectations of foster parents, discipline used by foster parents, religious training, school, contact with natural parents, and purpose of placement in foster care.

e. The foster parents' view of the child, the child's problem, placement worker's involvement, plan for the child, involvement of natural parents, and additional services that either the foster child or foster parents need.

f. Any previously or currently cited deficiencies, corrective action plans and progress.

g. Any previous or current concerns from department workers.

h. Discussion of placements during the licensing year and, if none, the reason why.

i. Progress on completing training in the foster parents' training plan.

j. Awareness of the foster parents' license capacity and compliance.

k. Recommended action.

113.15(3) An unannounced visit to the foster home:

a. Shall be completed annually;

b. Shall not be waived; and

c. Shall not occur in conjunction with license renewal.

113.15(4) The findings from the unannounced visit shall be summarized on Form 470-4512, Unannounced Visit Report.

a. The report shall be sent to the department licensing worker and the foster parents within two weeks after the visit.

b. A copy of the report shall be retained in the foster parents' record.

113.15(5) Actions after the unannounced visit.

a. When deficiencies are cited that do not appear likely to cause immediate physical or mental harm to the child, an additional visit may be scheduled. The department licensing worker and the recruitment and retention contractor shall discuss the deficiencies with the foster parents and make suggestions for improving the deficiencies.

b. When the reported deficiencies raise questions of concern as to the quality of care provided, the recruitment and retention contractor shall:

(1) Report deficiencies to the department licensing worker and to the placement worker for each foster child currently placed in the home;

(2) Hold a meeting with the department licensing worker and the foster parents to discuss deficiencies and suggestions for improving the deficiencies and complete a written corrective action plan as to how the foster parents intend to address the deficiencies.

c. When the reported deficiencies appear likely to cause immediate physical or mental harm to the child, the service area manager or designee shall immediately:

(1) Direct the placement worker to determine if the child should be removed, and

(2) Direct the licensing worker to complete a review of the foster home to determine if the family should continue to be licensed, should receive a provisional license, or should have the license revoked according to 441—112.6(237).

113.15(6) When the foster parents refuse to make a written commitment to improve the deficiencies, the department licensing worker shall conduct a complete review of the foster home to determine if the license should be revoked according to rule 441—112.6(237).

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.16(237) Planned activities and personal effects.

113.16(1) *Daily routine.* The daily routine shall promote good health and provide an opportunity for activity suitable for the foster child with time for rest and play.

113.16(2) *Clothing.*

a. All children should have their own clothing.

b. Children shall have training and help in selection and proper care of clothing.

c. Clothing shall be suited to the existing climate and seasonal conditions.

d. Clothing shall be becoming, of proper size, and of the character usually worn by children in the community.

e. There shall be an adequate supply of clothing to permit laundering, cleaning and repair.

f. There shall be adequate closet and drawer space for children to permit access to their clothing.

113.16(3) *Educational opportunity.* Every foster child shall be given the opportunity to complete high school or vocational training in accordance with the child's case permanency plan. The foster parent shall be an advocate for the foster child by working with the foster child's school.

113.16(4) *Religion and culture.* Each child shall be given an opportunity, in consultation with the child's parents, to participate in the child's culture and religion. Children shall not be required to participate in religious training or observances contrary to the wishes of the biological or adoptive family or the religious beliefs of the child.

113.16(5) *Community participation.* Every child shall be given the opportunity to develop healthy social relationships through participation in neighborhood, school and other community and group activities. The child shall have the opportunity to invite friends to the foster home and to visit the home of friends.

113.16(6) *Work assignments.* Work assignments shall be in keeping with the child's age and development.

a. Exploitation of the child is prohibited. No child shall be permitted to do any hazardous tasks or to engage in any work which is in violation of the child labor laws of the state.

b. Each child shall have the opportunity to learn to assume some responsibility for self and for household duties in accordance with the child's age, health and ability. However, assigned tasks shall not deprive the child of school, sleep, play or study periods.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.17(237) Medical examinations and health care of the child.

113.17(1) *Physical examinations.* Rescinded IAB 3/11/09, effective 5/1/09.

113.17(2) *Medical and dental supervision.* Each child shall be under regular medical and dental supervision. Foster parents shall keep the supervising worker informed of any health problems. In case of sickness or accident, immediate medical care shall be secured for the child in accordance with the supervising worker's directions given at the time of placement.

113.17(3) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization which is against medical treatment for disease. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.18(237) Training and discipline of foster children.

113.18(1) *Foster parents' methods of training and discipline.* The evaluation of the foster parent shall include a discussion and written report of the foster parents' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

113.18(2) *Restrictions on training and discipline.* Child training and discipline shall be handled with kindness and understanding.

a. A child shall not be locked in a room, closet, box, or other device.

b. No child shall be deprived of food as punishment.

c. No child shall be subjected to verbal abuse, threats or derogatory remarks about the child or the child's family.

d. The use of corporal punishment is prohibited.

e. Restraints shall not be used as a form of discipline.

(1) Reasonable physical force may be used to restrain a child only in order to prevent injury to the child, injury to others, the destruction of property, or extremely disruptive behavior.

(2) The foster parent shall receive training on the safe and appropriate use of restraints which has been approved as a part of the treatment plan by a licensed practitioner of the healing arts who is working with the child.

113.18(3) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the supervising worker shall be investigated promptly and referred to the proper authorities when necessary.

This rule is intended to implement Iowa Code sections 234.40 and 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.19(237) Emergency care and release of children.

113.19(1) *Supervision and arrangements for emergency care.*

a. Foster parents shall provide supervision of foster children and children in preadoptive placement as dictated by the individual child's specific needs.

b. In case of emergency requiring the foster parents' temporary absence from the home, arrangements shall be made with other licensed foster parents or with designated, responsible persons for the care of the children during the period of absence. The child's placement worker shall be notified of all emergency absences of the foster parents.

113.19(2) *Release of foster child.* The foster parents shall release the foster child only to the agency, parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.20(237) Changes in foster family home. Foster parents shall notify the department and the recruitment and retention contractor within seven working days of:

1. Any change in the number of persons living in the home (except for foster children);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of a child in the family's care.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

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◊ Two or more ARCs

CHAPTER 114
LICENSING AND REGULATION OF ALL GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 114]
[Prior to 2/11/87, Human Services[498]]

441—114.1(237) Applicability. This chapter outlines the basic standards for all group living foster care facilities and contains the basic standards applicable to community residential facilities for children. Additional standards applicable to specific levels of group living are discussed in 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Mentally Retarded Children."

This rule is intended to implement Iowa Code chapter 237.

441—114.2(237) Definitions.

"Adequate lighting" means a light intensity of 20 foot-candles (approximately equivalent to a 60 watt bulb at a clear distance of 5 feet).

"Caseworker" means any staff of the facility who is primarily responsible for planning for individual children, a family, or groups, as well as coordination with referral sources and coordination of services to the individual.

"Casework supervisor" means any staff of the facility who provides supervision of the caseworker(s) by regularly scheduled face-to-face case specific discussions with the caseworker.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications as a component of a service plan for a particular child is not considered chemical restraint.

"Child care worker" means any staff of the facility whose primary responsibility is the direct care of children in the facility.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Control room" means a locked room used for treatment purposes in a comprehensive residential facility.

"Educational degrees" means formally approved certificates from accredited schools.

"Highly structured juvenile program" means a short-term treatment program lasting 90 days and having a high degree of structure that stresses discipline, physical activity, and education. The program must be licensed either as a community residential facility under this chapter or as a comprehensive residential facility under 441—Chapter 115. The program shall have the ability to use a physically secure setting dependent upon the level of the license.

"Locked cottage" means an occupied comprehensive residential facility or an occupied unit of a comprehensive residential facility which is physically restrictive because of the continual locking of doors to prevent the children in care from leaving the facility.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the hands, arms, or legs.

"Physical restraint" means direct physical contact required on the part of a staff member to prevent a child from hurting self, others, or property.

"Prime programming time" means any period of the day when special attention or supervision is necessary, for example, upon awakening in the morning until departure for school, during meals, after school, transition between activities, evenings and bedtime, or weekends and holidays, in order to maintain continuity of program and care. Prime programming time shall be defined by the facility.

"Private juvenile detention home" means a juvenile detention home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in 441—subrule 105.1(2).

"Private juvenile shelter care home" means a juvenile shelter care home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in 441—subrule 105.1(2).

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

"Staff" means any person providing care or services to or on behalf of the facility whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.3(237) Physical standards. Local building and zoning ordinances shall be met.

114.3(1) *Grounds.*

a. An outdoor play area of 75 square feet per child shall be provided.

b. The play area shall be identified and kept free from hazards that could cause injury to a child.

c. Rubbish and trash shall be kept separated from the play area.

d. The grounds shall be adequately drained.

114.3(2) *Buildings.*

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceiling surfaced with materials that are asbestos free.

b. All sleeping rooms shall:

(1) Provide a minimum of 60 square feet per child for multiple occupancy.

(2) Provide a minimum of 80 square feet per child for single occupancy.

(3) Not sleep more than four children per room. Facilities licensed prior to July 1, 1981, meeting current square footage requirements shall be allowed to house five children per room.

(4) Be of finished construction.

Facilities licensed prior to July 1, 1981, having a square foot area less than that required in subparagraphs (1) and (2) shall be considered to meet those standards.

c. All rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. All rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

114.3(3) *Bedrooms.*

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases, and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private use, and a designated space for hanging clothing in proximity to the bedroom occupied by the child.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

114.3(4) *Heating.*

a. The heating unit shall be located and operated to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters and water heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas heaters.

d. The heating or cooling plant shall be checked at least annually and kept in safe working condition at all times.

This rule is intended to implement Iowa Code section 237.3.

441—114.4(237) Sanitation, water, and waste disposal.

114.4(1) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given these items. Paper towels, when used, and toilet tissue shall be in dispensers.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by an enclosed solid door.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

114.4(2) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen foods shall be kept at zero degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or below.

f. The kitchen and food storage areas shall be kept clean and neat. Foods shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

114.4(3) *Personnel handling food.* Personnel who handle food shall:

a. Be free of infection.

b. Be clean and neatly groomed.

c. Wear clean clothes.

d. Not use tobacco in any form while preparing or serving food.

114.4(4) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or less people at one meal.

b. Commercial dishwashers shall be used in facilities serving more than 15 people at one meal, and shall meet the following criteria:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain wash water at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All hand-held food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns, and similar equipment shall be cleaned and sanitized daily.

114.4(5) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform with all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food maintained at 45 degrees Fahrenheit or below.

114.4(6) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade A.

114.4(7) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

114.4(8) *Private water supplies.*

a. Each privately operated water supply shall be annually checked and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples shall be collected and submitted by the department of human service worker or local health sanitarian to the state hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria and nitrate (NO^3) content.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When no apparent deficiencies exist in the well and the water sample is approved, water safety requirements have been met.

e. When the water sample is not approved, the facility shall provide a written statement as to how the water supply will be upgraded.

f. A facility can obtain potable water from another source when a written statement is provided on where the water will be obtained and the manner of transportation and storage until the water supply is tested as safe. This shall be considered as meeting the water safety requirements.

114.4(9) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

114.4(10) *Sewage treatment.*

a. Facilities shall be connected to public sewer systems where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

114.4(11) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, leakproof, and rodent proof and shall be maintained in a sanitary condition.

This rule is intended to implement Iowa Code section 237.3.

441—114.5(237) Safety.

114.5(1) *General.*

a. Facilities shall take sufficient measures to ensure the safety of the children in care.

b. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

c. Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

d. Fuse boxes shall be inaccessible to children.

e. Facilities shall have written procedures for the handling and storage of hazardous materials.

f. Firearms and ammunition shall be kept under lock and key and inaccessible to children. When firearms are used, the facility shall have written policies regarding their purpose, use, and storage.

g. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

h. The facility shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the institution grounds and accessible to the children.

114.5(2) *Emergency evacuation.* All living units utilized by children shall have a posted plan for evacuation in case of fire or disaster with practice drills held at least every six months.

This rule is intended to implement Iowa Code section 237.3.

441—114.6(237) Organization and administration. Any change in the name of the facility, the address of the facility, the executive, or the capacity shall be reported to the licensing manager.

114.6(1) *Table of organization.* A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff.

114.6(2) *Purpose of agency.* The purpose or function of the organization shall be clearly defined in writing and shall include a description of the children to be accepted for care and the services offered.

114.6(3) *Governing bodies or individuals.* All group living foster care facilities shall:

a. Have a governing board or individuals who are accountable for and have authority over the policies and activities of the organization. In the case of an organization owned by a proprietor or partnership, the proprietor or partner shall be regarded as the governing body.

b. Provide the department with a list of names, addresses, telephone numbers and titles of the members of the governing body.

c. Have adequate insurance covering fire and liability as a protection to children in care.

d. For organizations with the home base located outside Iowa, have duly authorized representatives with decision-making abilities designated within the state of Iowa.

114.6(4) *Executive director.* The governing body shall select and appoint an executive director with full administrative responsibility for carrying out the policies, procedures and programs established by the governing body.

114.6(5) *Financial solvency of facilities.* Profit and nonprofit institutions shall maintain financial solvency to ensure adequate care of children and youth for whom responsibility is assumed. It shall have sufficient financial resources, predictable income, or both, and not be totally dependent upon current fees, for a three-month operating period. The facility shall have written policies and procedures describing the program of the facility and specifying how it will be carried out.

This rule is intended to implement Iowa Code section 237.2.

441—114.7(237) Policies and record-keeping requirements.

114.7(1) *Policies in writing.* The following current personnel policies and practices of the agency and relating to the specific facility shall be described in writing and accessible to staff upon request:

a. Affirmative action and equal employment opportunity policies and procedures covering the hiring, assignment, and promotion of employees.

b. Job descriptions for all positions.

c. Provisions for vacations, holidays, and sick leave.

d. Effective, time-limited grievance procedures allowing the aggrieved party to bring the grievance to at least one level above that party's supervisor.

e. Authorized procedures, consistent with due process, for the suspension and dismissal of an employee for just cause.

f. Written procedures for annual employee evaluations.

114.7(2) *Health of staff.* Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties. A statement attesting to these facts shall be secured at the time of employment and filed in the staff record of the staff person. A new statement shall be secured at least every three years. The statement shall be signed by one of the following:

a. A physician as defined in Iowa Code section 135.1(4);

b. An advanced registered nurse practitioner who is registered with and certified by the Iowa board of nursing to practice nursing in an advanced role; or

c. A physician assistant licensed under Iowa Code chapter 148C.

114.7(3) *Staff records.*

a. The facility shall maintain the following information with respect to each staff person:

(1) Name and current address of each staff person.

(2) At least two written references or documentation of oral references. In case of unfavorable references, there shall be documentation of further checking to ensure that the person will be reliable.

(3) Documentation that a criminal records check with the Iowa division of criminal investigation has been completed on the staff person prior to providing any care or service directly or indirectly to children under the care of the agency. A copy of the department's evaluation of the criminal record check shall be kept in the staff record.

(4) A written, signed and dated statement furnished by the staff person prior to providing any care or services to or on behalf of the facility which discloses any founded reports of child abuse on the person that may exist.

(5) Documentation that a check of the staff person has been completed with the Iowa central abuse registry for any founded reports of child abuse prior to the person's providing any care or services directly or indirectly to children under the care of the agency. A copy of the department's evaluation of this child abuse record check shall be kept in the staff record.

(6) Records of a health examination or a record of a health report, as required in subrule 114.7(2), plus a written record of subsequent health services rendered to staff necessary to ensure that each individual is physically able to perform the job duties or functions.

(7) If the staff person has completed and submitted Form 470-2310, Record Check Evaluation, to the agency, a copy shall be kept in the staff record.

(8) Records of training sessions attended, including dates and content of the training.

(9) When otherwise required in situations that apply, a certified copy of a school transcript, diploma, or written statement from the school or supervising agency for positions having educational requirements.

b. In addition, with respect to staff who are employed by the facility, the facility shall maintain the following records:

(1) Social security number of each employee.

(2) A job application containing sufficient information to justify the initial and current employment.

(3) A certified copy of a school transcript, diploma, or written statement from the school or supervising agency before permanent employment of applicants for positions having educational requirements.

(4) Written verification of licensure before permanent employment of applicants for positions requiring licenses. Evidence of renewal of licenses as required by the licensing agency.

(5) Current information relative to work performance evaluation.

(6) Information on written reprimands or commendations.

(7) Information on position in the agency and date of employment.

(8) If the applicant, probationary or temporary employee has completed and submitted Form 470-2310, Record Check Evaluation, to the agency, a copy shall be kept in the staff record.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.8(237) Staff.

114.8(1) *Qualifications of staff.*

a. A caseworker shall have a bachelor of arts or bachelor of science degree in social work, psychology or a related behavioral science, plus two years of supervised experience; or a bachelor's degree in social work with one year of supervised experience; or six years of supervised child welfare experience in residential care or a combination of advanced education in the behavioral sciences and experience equal to six years.

b. A casework supervisor shall have either a master's degree in social work with one year of supervised experience after the master's degree or a master's degree in psychology or counseling with two years of experience beyond the master's degree, one of which was under supervision. The experience shall be in the area of child welfare services.

c. Child care workers shall be at least 18 years of age.

d. Any licensed facility having persons in employment in positions for which present rules require higher qualifications will be considered to meet rules with the present staff. New staff will need to meet the requirements of these rules.

e. A person who has a record of a criminal conviction or founded child abuse report shall not be employed, unless an evaluation of the crime or founded child abuse has been made by the department which concludes that the crime or founded child abuse does not merit prohibition of employment. If a record of criminal conviction or founded child abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310, "Record Check Evaluation." In its evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, and the number of crimes or founded abuses committed by the person involved.

114.8(2) *Number of staff.*

a. Children shall be provided with 24-hour awake supervision. There shall be at least one awake and readily accessible staff person on duty for each currently occupied living unit. The staff person shall make regular visual checks at least every hour throughout the night. A log shall be kept of all checks, including the time of the check and any significant observations. Policies for nighttime checks shall be in writing.

b. Each facility shall have the services of a casework supervisor and a caseworker adequate to fulfill the staff duties.

c. There shall be an on-call system operational 24 hours a day to provide supervisory consultation. There shall be a written plan documenting this system.

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during prime programming time.

114.8(3) *Staff duties.*

a. The casework supervisor shall provide in-person case specific supervision at the site of the facility for one hour per month per caseworker and be available for consultation in case of emergency.

b. Caseworkers shall:

(1) Develop a care plan for each child containing goals and objectives with projected dates of accomplishment and shall involve the client, referral agency, and family whenever possible.

(2) Develop a specific plan relating to the involvement of the child's parents unless documented by the caseworker that their involvement would be counterproductive.

c. The facility shall define in writing who shall be responsible for the following staff duties:

(1) Documenting case reassessments quarterly, involving the same personnel as previously involved in care plan development.

(2) Documenting the implementation of the care plan.

(3) Providing for scheduled in-person conferences with each resident.

(4) Providing a supportive atmosphere for the child.

(5) Providing for coordination of internal and external activities of the child.

(6) Providing for liaison with the referring agency.

(7) Providing leadership and guidance to the children.
(8) Providing a mechanism for dealing with day-to-day program operations.
(9) Being responsible for overseeing and maintaining general health and well-being of children.
(10) Supervising the living activities of the children.
(11) Monitoring and recording behavior on a daily basis.
(12) At all times, knowing where the children are supposed to be.

114.8(4) *Staff development.* Staff development shall be appropriate to the size and nature of the facility. There shall be a written format for staff training that includes:

a. Orientation for all new employees to acquaint them with the philosophy, organization, program practices, and goals of the facility.

b. Training of new employees in areas related to their job assignments.

c. Provisions for all staff members to improve their competency. This may be accomplished through such means as:

(1) Attending staff meetings.
(2) Attending seminars, conferences, workshops and institutes.
(3) Visiting other facilities.
(4) Access to consultants.
(5) Access to current literature, including books, monographs, and journals relevant to the facility's services.

d. An individual designated responsible for staff development and training, who will complete a written staff development plan which shall be updated annually.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.9(237) Intake procedures.

114.9(1) *Intake policies.* The agency shall have written intake policies specific to the licensed facility.

114.9(2) *Basis of acceptance.* Children shall be accepted for care only after the following criteria have been met:

a. An assessment of the child's need for service and supervision has been agreed upon by the staff of the facility and the referring agency worker. The child, the child's family, and any other significant people shall be invited to participate in this process to the fullest extent possible.

b. The assessment indicates that the child requires the care offered by this type of facility and is likely to benefit from the program the facility offers.

114.9(3) *Referral requirements.* The following information shall be available prior to any decision being made regarding the acceptance of a child:

a. A current social history.

b. A copy of the child's physical assessment including immunization history completed within one year prior to application, when available.

c. Where indicated, or when available, psychological testing completed no more than one year prior to referral.

d. Current educational data.

e. When indicated or available, psychiatric report completed no more than one year prior to referral.

f. Referring agency's case plan which includes goals and objectives to be achieved during placement with a time frame for the achievement of these goals and objectives.

g. Documentation of the legal status of the child which includes any court orders or statements of custody and guardianship.

114.9(4) *Admission requirements.*

a. The following items shall be secured upon admission of the child to the facility.

(1) A placement agreement for the child signed by the person having legal responsibility for the child and the agency where the child is being placed. When this is not available at the time of placement, it shall be furnished within 48 hours of placement in the facility.

(2) Emergency medical authorization from the court, the parents, the guardian, or custodian.

b. The following items shall be provided to the child, the child's family or guardian, and the referring worker at the time of placement:

(1) A description of the services provided.

(2) Written policies regarding children's rights as in 114.13(2).

(3) Written policies regarding religion, work or vocational experiences, family involvement, grievance procedures and discipline as in 441—114.13(237) to 114.18(237) and 114.20(237).

114.9(5) *Personal assessment.* At the time of intake, individual needs will be identified by staff based on written and verbal information from referral sources, observable behavior at intake and the initial interview with youth or family, school contacts, physical examinations, and other relevant material. The individual assessment shall provide the basis for development of a care plan for each child.

114.9(6) *Educational assessment.* An educational assessment shall be developed by the staff and the referring worker. Involvement of the parents or guardian, area education agency, and public schools may be appropriate.

114.9(7) *Person responsible.* Each agency shall designate a person or persons who have the authority to do intake.

114.9(8) *Intake sheet.* An intake sheet shall be completed on each child containing at least the information specified in 114.11(2).

This rule is intended to implement Iowa Code section 237.3.

441—114.10(237) Program services.

114.10(1) *Evaluation services.*

a. When evaluation services are provided by staff of the facility, the services shall be clearly defined so that referral sources are clear about the components of the service.

b. Evaluations shall be based on behavioral observations, social history, educational assessments and shall include an assessment of vocational needs, recreational skills, and physical therapy, speech, language, vision and hearing needs to assist in planning and placement for the child. The need for providing all of these evaluative services will be determined on the basis of the specific child being referred.

114.10(2) *Care plan.* There shall be a written care plan for each child. The care plan shall be based on the individual needs determined through the assessment of each resident, provide for consultation with the family, and shall include the following:

a. Identification of special needs.

b. Description of planned services which indicate which staff person will be responsible for the specific services in the plan.

c. Indication of where the services are to occur and note the frequency of activities or services.

114.10(3) *Daily routine.* Each facility shall provide a daily routine for the children in residence which is directed toward developing healthful habits in eating, sleeping, exercising, personal care, hygiene, and grooming according to the needs of the individual child and the living group.

114.10(4) *Daily log.* The facility shall maintain a daily log. The log shall be used to note general progress in regard to the care plan and any problem areas or unusual behavior for each child.

114.10(5) *Educational services.* An educational program shall be available for each child in accordance with abilities and needs. The educational and teaching standards established by the state department of education shall be met when an educational program is provided within an institution.

114.10(6) *Health care.*

a. There shall be 24-hour emergency and routine medical and dental services available and provided when prescribed. Provisions for these services shall be documented.

b. The facility shall arrange a physical assessment including vision and hearing tests for each child in care within one week of admission unless the child has received an examination within the past year and the results of this examination are available to the facility.

c. A facility shall not require medical treatment when the parent(s) or guardian of the child or the child objects to treatment on the grounds that it conflicts with the tenets and practices of a recognized church or religious denomination of which the parent(s), guardian or child is an adherent. In potentially life-threatening situations, the facility shall refer the child's care to appropriate medical and legal authorities.

d. A facility shall have written procedures for staff members to follow in case of medical emergency.

e. A facility shall schedule a dental examination for each child within 14 days of admission unless the child has been examined within six months prior to admission and the facility has the results of that examination.

114.10(7) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the special food needs and tastes of children.

114.10(8) *Recreation and leisure activities.*

a. A facility shall provide the opportunity for recreation and leisure activities for children in care.

b. Opportunities shall be based on both the individual interests and needs of the children in care and the composition of the living group.

c. A facility shall utilize the recreational resources of the community whenever appropriate.

114.10(9) *Casework services.* A facility shall provide or obtain casework services in the form of counseling in accordance with the needs of each child's individual care plan. Casework services include crisis intervention, daily living skills, interpersonal relationships, future planning and preparation for placement as required by the child.

114.10(10) *Psychiatric and psychological services—(Optional service).*

a. When the diagnostic evaluation of a child indicates need for care by a psychiatrist and under psychiatric guidance, the specialized treatment or consultation shall be provided or arranged by the facility.

b. Psychologists, whose services are used in behalf of children, shall be licensed as a psychologist in the state of Iowa, or be certified by the department of education.

114.10(11) *Volunteers—(Optional service).* A facility which utilizes volunteers to work directly with a particular child or group of children, shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

a. Be directly supervised by a paid staff member.

b. Be oriented and trained in the philosophy of the facility and the needs of children in care, and methods of meeting those needs.

c. Be subject to character and reference checks required of employment applicants.

This rule is intended to implement Iowa Code section 237.3.

441—114.11(237) Case files.

114.11(1) *Generally.* All facilities shall establish and maintain case files on each child. The case files shall include the following:

114.11(2) *Face sheet.* The face sheet shall contain the following information:

a. Full name, birth place and date of birth.

b. Parents' full name.

c. Parents' address and telephone number.

d. Religious preference of parents and child.

e. Statement of who has legal custody and guardianship.

f. Name of the referring worker and agency making the referral.

g. Telephone number and address of the agency or court making the referral.

114.11(3) *Referral packet.* All of the information required in the referral packet shall be contained in the case record including a social history on the child, a copy of the child's physical assessment

and immunization history, psychological testing, when available, current educational information, psychiatric report, when available, and the referring agency's case plan.

114.11(4) *Legal documents.*

a. Placement agreement signed by parent(s) or custodian of the child.

b. Petitions and orders of the court regarding adjudication, custody, or guardianship.

114.11(5) *Psychiatric and psychological.* Psychiatric and psychological reports, when available.

114.11(6) *Correspondence.* Correspondence regarding the child.

114.11(7) *Medical.*

a. Medical and surgical authorizations signed by the parent(s), guardian, or contained in the court order.

b. Record of medical care received while in the facility.

c. Information on past medical history.

114.11(8) *School.*

a. Name of school currently attended.

b. Grade placement.

c. Any specific educational problem.

d. Remedial action recommended.

114.11(9) *Care plan.* Individual child care plan and semiannual review and revision of care plan.

114.11(10) *Dictation.*

a. Appropriate notes, all significant contacts with parents, referring worker and other collateral contracts, as well as staff counseling with child and notations on behavior.

b. Information on release of the child from the facility including the name, address and relationship of the person or agency to whom the child was released.

This rule is intended to implement Iowa Code section 237.3.

441—114.12(237) Drug utilization and control. The agency shall have written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are to be allowed in the facility without the authorization of a licensed physician.

114.12(1) *Approved drugs.* Only drugs which have been approved by the federal Food and Drug Administration for use in the United States may be used. No experimental drugs may be used.

114.12(2) *Prescribed by physician.* Drugs shall be prescribed by a physician licensed to practice in the state of Iowa or the state in which the physician is currently practicing and may be prescribed only for use in accordance with dosage ranges and indications approved by the federal Food and Drug Administration.

114.12(3) *Dispensed from a licensed pharmacy.* Drugs provided to residents shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Code of Iowa, or from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

114.12(4) *Locked cabinet.* All drugs shall be maintained in a locked cabinet. Controlled substances shall be maintained in a locked box within the locked cabinet. The cabinet key shall be in the possession of a staff person. A bathroom shall not be used for drug storage. A documented exception can be made by a physician for self-administered drugs as discussed in 114.12(17).

114.12(5) *Medications requiring refrigeration.* Medications requiring refrigeration shall be kept in a locked box in the refrigerator and separated from food and other items.

114.12(6) *Poisonous or caustic drugs.* All potent poisonous or caustic drugs shall be plainly labeled, stored separately from other drugs in a specific well-illuminated cabinet, closet, or storeroom, and made accessible only to authorized persons.

114.12(7) *Prescribed medications.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of the drug, dosage, directions for use and, date of issuing the drug. Medications shall be packaged and labeled according to state and federal guidelines.

114.12(8) *Medication containers.* Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist.

114.12(9) *Medication for discharged residents.* When a resident is discharged or leaves the facility, medications currently being administered shall be sent, in the original container, with the resident or with a responsible agent, and with the approval of the physician.

114.12(10) *Unused prescription drugs.* Unused controlled prescription drugs prescribed for residents shall be returned to the issuing pharmacist or physician for credit or destruction according to state law. Other unused prescription drugs shall be destroyed by facility staff in the presence of a witness and this destruction shall be documented.

114.12(11) *Refills.* Prescriptions shall be refilled only with the permission of the attending physician.

114.12(12) *Use of medications.* No prescription medications prescribed for one resident may be administered to or allowed in the possession of another resident.

114.12(13) *Order of physician.* No prescription medication may be administered to a resident without the order of a licensed physician.

114.12(14) *Patient reaction.* Any unusual patient reaction to a drug shall be reported to the attending physician immediately.

114.12(15) *Dilution or reconstitution of drugs.* Dilution or reconstitution of drugs and their labeling shall be done only by a licensed pharmacist.

114.12(16) *Administration of drugs.* Medications shall be administered only in accordance with the instructions of the attending physician. Controlled substances shall be administered only by qualified personnel. The type and amount of the medication, the time and date, and the staff member administering the medication shall be documented in the child's record. (See IAC 620—8.16(204).)

114.12(17) *Self-administration of drugs.* There shall be written policy and procedures relative to self-administration of prescription medications by residents and only when:

a. Medications are prescribed by a physician.

b. The physician agrees that the patient can self-administer the drug.

c. What is taken and when is documented in the record of the child.

This rule is intended to implement Iowa Code section 237.3.

441—114.13(237) Children's rights.

114.13(1) *Policies in writing.* All policies and procedures covered in this rule shall be in writing and provided to the child and parents or guardian upon the child's admission to the facility. The rationale and circumstances of any deviation from these policies shall be discussed with the child's parents or guardian and the referring worker, documented, and placed in the child's case record.

114.13(2) *Confidentiality.* Information regarding children and their families shall be kept confidential and released only with proper written authority.

114.13(3) *Communication.*

a. Visitation shall be allowed with members of the child's immediate family unless otherwise regulated by the court.

b. Visits shall be allowed with other significant persons.

c. Consideration shall be given to privacy for family visits.

d. The child shall be permitted to communicate with legal counsel and the referring worker.

e. The child shall be allowed to conduct private telephone conversations with family members. Incoming calls may be screened by staff to verify the identity of the caller before approval is given.

f. The child shall be allowed to send and receive mail. The facility may require the child to open incoming mail in the presence of a staff member when it is suspected to contain contraband articles, or when there is money that should be receipted and deposited.

g. When limitations on visitation, calls or other communications are indicated, they shall be determined with the participation or knowledge of the child, family or guardian, and the referring worker. All restrictions shall have specific bases which shall be made explicit to the child and family and documented in the child's case record.

114.13(4) *Privacy.* Reasonable provisions shall be made for the privacy of residents.

This rule is intended to implement Iowa Code section 237.2.

441—114.14(237) Personal possessions.

114.14(1) *Belongings.* A facility shall allow a child in care to bring personal belongings and to acquire belongings in accordance with the child's service plan. However, the facility shall, as necessary, limit or supervise the use of these items while the child is in care.

114.14(2) *Clothing.* A facility shall ensure that each child in care has adequate, clean, well-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being. The clothes should be appropriate to age, sex and individual needs.

This rule is intended to implement Iowa Code section 237.2.

441—114.15(237) Religion—culture.

114.15(1) *Facility orientation.* A facility shall have a written description of its religious orientation, particular religious practices that are observed, and any religious restrictions. This description shall be provided to the child, the parent(s) or guardian, and the placing agency at the time of admission.

114.15(2) *Child participation.* When a facility accepts a child, the child shall have the opportunity to participate in religious activities and services in accordance with the child's own faith or that of the child's parent(s) or guardian. The facility shall, when necessary and reasonable, arrange transportation for religious activities. Wherever feasible, the child shall be permitted to attend religious activities and services in the community.

This rule is intended to implement Iowa Code section 237.2.

441—114.16(237) Work or vocational experiences.

114.16(1) *Written description.* The facility shall have a written statement of any work and vocational experiences available to children.

114.16(2) *Program component.* Work as part of the program shall be identified in the child's case plan.

114.16(3) *Self-care.* Ordinary self-care and self-sufficiency tasks are not considered work.

114.16(4) *Purpose.* Work shall be in the child's interest, within the child's ability, with payment where appropriate, and never solely in the interest of the facility's goals or needs.

This rule is intended to implement Iowa Code section 237.2.

441—114.17(237) Family involvement. There shall be written policies and procedures for family involvement that shall encourage continued involvement of the family with the child.

This rule is intended to implement Iowa Code section 237.2.

441—114.18(237) Children's money.

114.18(1) *Treatment of funds.* Money earned, received as a gift, or as an allowance by a child in care shall be deemed to be that child's personal property.

114.18(2) *Limitations.* The facility shall have a written policy on limitations on the child's use of funds.

114.18(3) *Records.* The facility shall maintain a separate accounting system for children's money.

This rule is intended to implement Iowa Code section 237.2.

441—114.19(237) Child abuse. Written policies shall prohibit mistreatment, neglect, or abuse of children and specify reporting and enforcement procedures for the facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Any employee found to be in violation of Iowa Code chapter 232, division III, part 2, as substantiated by the department of human services' investigation shall be subject to the agency's policies concerning dismissal.

This rule is intended to implement Iowa Code section 237.2.

441—114.20(237) Discipline.

114.20(1) *Generally.* The facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep.

114.20(2) *Corporal punishment prohibited.* The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated, in writing, to all staff of the facility.

114.20(3) *Physical restraint.* The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

114.20(4) *Other restraints.* Only comprehensive residential facilities may use a control room, locked cottages, mechanical restraints or chemical restraint.

114.20(5) *Behavior expectations.* The facility shall make available to the child and the child's parents or guardian written policies regarding the following areas:

a. The general expectation of behavior including the facility's rules and practices.

b. The range of reasonable consequences that may be used to deal with inappropriate behavior.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.21(237) Illness, accident, death, or absence from the facility.

114.21(1) *Notification of illness.* A facility shall notify the child's parent(s), guardian and responsible agency of any serious illness, incident involving serious bodily injury, or circumstances causing removal of the child from the facility.

114.21(2) *Notification of death.* In the event of the death of a child, a facility shall notify immediately the physician, the child's parent(s) or guardian, the placing agency, and the appropriate state authority. The agency shall cooperate in arrangements made for examination, autopsy, and burial.

This rule is intended to implement Iowa Code section 237.2.

441—114.22(237) Records. In the event of closure of a facility, children's records shall be sent to the department of human services for retention according to the records retention policy.

This rule is intended to implement Iowa Code section 237.2.

441—114.23(237) Unannounced visits.

114.23(1) *Time.* The unannounced visit shall occur during periods of the day when the child would normally be in the facility and awake. Visits at other times may occur only as a result of a specific complaint.

114.23(2) *Observations.* The visit shall include an assessment of the following areas:

a. Interaction between the staff and child.

b. Interaction between the children.

c. Discussion with the child about experiences in the facility.

d. A check on any previously sighted deficiencies.

e. Overall impression of the facility.

114.23(3) *Recommendation.* The licensing staff shall recommend follow-up, when needed.

This rule is intended to implement Iowa Code section 237.7.

441—114.24(237) Standards for private juvenile shelter care and detention homes. The standards of 441—Chapter 105 shall be used as the basis for licensing private juvenile shelter care and detention homes. These homes are not required to meet other standards of 441—Chapter 114.

This rule is intended to implement Iowa Code section 237.3.

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CHAPTER 115
LICENSING AND REGULATION OF COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 115]
[Prior to 2/11/87, Human Services[498]]

441—115.1(237) Applicability. This chapter relates specifically to the licensing and regulation of comprehensive residential care facilities. Refer to 441—Chapter 112 for the basic licensing and regulation of all foster care facilities and 441—Chapter 114 for definitions and minimum standards for all group living foster care facilities.

This rule is intended to implement Iowa Code chapter 237.

441—115.2(237) Definitions.

"Comprehensive residential facility" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual treatment plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, mechanical restraints, and chemical restraints when these controls meet licensing requirements.

"Nonsecure facility" means any facility which does not meet the definition of a secure facility.

"Secure facility" means any comprehensive residential facility which employs, on a regular basis, locked doors or other physical means to prevent children in care from leaving the facility. Secure facilities may only be used for children who have been adjudicated delinquent or placed pursuant to provisions of Iowa Code chapter 229.

This rule is intended to implement Iowa Code chapter 237.

441—115.3(237) Information upon admission. In addition to the requirements in 114.9(4)*"b,"* parents or guardians shall be provided with information on conditions for the use of restraints.

This rule is intended to implement Iowa Code section 237.3.

441—115.4(237) Staff.

115.4(1) *Number of staff.*

a. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to five staff to child ratio during prime programming time.

b. A staff person shall be in each living unit at all times when children are in residence.

115.4(2) *Staff duties.*

a. A casework supervisor shall provide:

(1) One hour per week per caseworker of in-person case specific supervision.

(2) On-site supervision at least monthly.

(3) At least one additional hour per week per caseworker in other related duties including case intake discussions, staffings of cases, evaluations of caseworker, teaching, and administrative duties.

b. Casework staff shall:

(1) Provide at least weekly group or individually scheduled in-person conferences with each resident for whom the caseworker is responsible. More frequent in-person contact shall be provided if required in the care plan.

(2) Provide a supportive and therapeutic atmosphere for the child.

(3) Select and employ appropriate treatment approaches to different types of children.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—115.5(237) Program services.

115.5(1) *Recreation program.*

a. The facility shall provide adequately designed and maintained indoor and outdoor activity areas, equipment, and equipment storage facilities appropriate for the age group it serves. There shall be a variety of activity areas and equipment so that all children can be active participants in different types of individual and group sports and other motor activities.

b. Games, toys, equipment, and arts and crafts material shall be selected according to the age and number of children with consideration to the needs of the children to engage in active and quiet play.

c. The facility shall plan and carry out efforts to establish and maintain workable relationships with community recreational resources so these resources may provide opportunities for children to participate in community recreational activities.

115.5(2) *Casework services.* The facility shall have the internal capacity to provide individual, family and group counseling and shall include, but not be limited to, casework dealing with crisis intervention, daily living skills, peer relationships, future planning and preparation for discharge.

This rule is intended to implement Iowa Code section 237.3.

441—115.6(237) Restraints.

115.6(1) *Nonsecure facilities.* Physical restraints and a control room are permitted in nonsecure facilities.

115.6(2) *Secure facilities.* Secure facilities may use physical restraints, a control room, locked cottages, mechanical restraints, and chemical restraints.

115.6(3) *Written policies.* A facility which uses restraints shall have a written policy on their use. This policy shall include:

a. A statement specifically identifying each form of restraint in use at the facility.

b. Criteria for use of each form of restraint.

c. Identification of staff authorized to approve and use each form of restraint.

d. Requirement for documentation in the child's individual case file.

e. Procedures for application or administration of each form of restraint.

f. Maximum time limit for use of restraints.

115.6(4) *Use of restraint.*

a. A facility shall not use, apply, or administer restraint in any manner which causes physical injury.

b. A facility shall not use restraint as a disciplinary or punitive measure, for staff convenience, or as a substitute for programming.

c. A secure facility which uses any form of restraint other than physical restraint shall ensure that all direct service staff are adequately trained in the following areas:

(1) The appropriate use and application or administration of each approved form of restraint.

(2) The facility's policies and procedures related to restraint.

(3) Crisis management techniques.

d. A secure facility shall continually review any placement of a child in any form of restraint other than physical restraint. The facility shall release the child from restraint immediately when the situation precipitating restraint no longer exists.

This rule is intended to implement Iowa Code section 237.4.

441—115.7(237) Control room.

115.7(1) *Purpose.* The control room shall be used for treatment purposes only. A facility shall be approved by the licensing authority as meeting the requirements of this chapter regarding control rooms before control rooms can be utilized.

115.7(2) *Written policies.* When a residential treatment facility uses a control room as part of its treatment program, the facility shall have written policies regarding its use. The policy shall:

a. Specify the types of behavior which may result in control room placement.

b. Delineate the staff members who may authorize its use as well as procedures for notification of supervisory personnel.

c. Require documentation in writing of the types of behaviors leading to control room placement and the conditions that will allow the child to return to the living unit. The child shall be informed of these conditions.

d. Limit the utilization of the control room to one of the following two circumstances:

(1) The child's care plan includes and explains how this use of the control room fits into the treatment plan for the child.

(2) A one time placement in an emergency without a care plan outlining the rationale for its use. This treatment shall be included in the care plan for a second placement of a child in the control room.

115.7(3) *Physical requirements.* The control room shall be designed to ensure a physically safe environment with:

a. All switches controlling lights and ventilation outside the room.

b. Allowance for observation of the child at all times.

c. Protected recessed ceiling light.

d. No electrical outlets in the room.

e. Proper heating, cooling, and ventilation.

f. Any window secured and protected in a manner to prevent harm to the child.

g. A minimum of 54 square feet in floor space with at least a 7-foot ceiling.

115.7(4) *Use of control room.* The control room shall be used only when a less restrictive alternative to quiet or allow the child to gain control has failed and when it is in the care plan. The following policies shall apply to the use of the control room:

a. No more than one child shall be in a control room at any time.

b. There shall be provisions for visual observation of the child at all times, regardless of the child's position in the room.

c. The control room shall be checked thoroughly for safety and the absence of contraband prior to placing the child in the room.

d. The child shall be thoroughly checked before placement in the control room and all potentially injurious objects removed including shoes, belts, and pocket items. The staff member placing the child in the control room shall document each check.

e. In no case shall all clothing or underwear be removed and the child shall be provided sufficient clothing to meet seasonal needs.

f. A staff member shall always be within hearing distance of the control room, the child shall be visually checked by the staff at least every 15 minutes, and each check shall be recorded.

g. The child shall remain in the control room longer than one hour only with consultation and approval from the supervisor. Documentation in the child's case record shall include the time in the control room, the reasons for the control, and the reasons for the extension of time. Use of the control room for a total of more than 12 hours in any 24-hour period shall occur only after authorization of the psychiatrist or upon court order. In no case shall a child be in a control room for a period longer than 24 hours.

h. The child's parents or guardian and the referring worker shall be aware of the control room as a part of the treatment program.

This rule is intended to implement Iowa Code section 237.4.

441—115.8(237) Locked cottages.

115.8(1) *Approval.* A facility shall be approved by the licensing authority as meeting the requirements of this chapter regarding locked cottages before locked cottages can be operated.

115.8(2) *Nighttime staff.* Awake nighttime staff is required in each locked cottage.

115.8(3) *As one unit of treatment program.* When a facility utilizes a locked cottage as one unit of its treatment program, it shall have written policies. The policies shall be provided to the child, the child's parents or guardian and, when the child has an attorney, the child's attorney at the time of admission. The policies shall include:

a. The type of behavior which may result in locked cottage placement.

b. The staff members who may authorize placement in the locked cottage as well as procedures for notification of supervisory personnel.

c. Requirement for documentation in writing of particular behaviors of a particular child that led to the locked cottage placement.

d. Requirement for documentation of the conditions that will allow the child to return to an unlocked cottage. These conditions shall be shared with the child.

e. Requirement for documentation of the use of the locked cottage as a part of the treatment plan for a specific child.

f. Specific policies as to the length of stay in the locked cottage.

g. Requirements for notification of the child's parents or guardian, the court, and the referring agency of a child's placement in the locked cottage.

h. Requirement for written documentation of placements in the locked cottage in the child's case record.

This rule is intended to implement Iowa Code section 237.4.

441—115.9(237) Mechanical restraint. When a facility uses mechanical restraints as a part of its treatment program, the facility shall have written policies regarding their use. These policies shall be approved by the licensor prior to their use. The policies shall be available to clients, parents or guardians, and referral sources at the time of admission. Policies shall also be available to staff.

115.9(1) *Restrictions on mechanical restraints.*

a. Mechanical restraints shall not inflict physical injury.

b. Each use of mechanical restraint shall be authorized by the administrator or case supervisor.

c. Each authorization of mechanical restraint shall not exceed one hour in duration.

d. No child shall be kept in mechanical restraint for more than two hours in a 12-hour period.

e. Any time that a child is placed in mechanical restraint a staff person shall be assigned to monitor the placement with no duties other than to ensure that the child's physical needs are properly met. The staff person shall remain in continuous auditory and visual contact with the child.

f. Each child shall be released from mechanical restraint as soon as the restraints are no longer needed.

115.9(2) *Continued use of mechanical restraints.* When a child requires mechanical restraint on more than four occasions during any 30-day period, the facility shall hold an immediate emergency meeting to discuss the appropriateness of the child's continued placement at the facility.

115.9(3) *In transporting children.* Notwithstanding 115.9(1)*"d,"* mechanical restraint of a child in case of a secure facility while that child is being transported to a point outside the facility is permitted when there is a serious risk of the child exiting the vehicle while the vehicle is in motion. The facility shall place a written report on each use in the child's case record. This report shall document the necessity for the use of restraint.

This rule is intended to implement Iowa Code section 237.4.

441—115.10(237) Chemical restraint. When a secure facility uses chemical restraints, the facility shall have written policies regarding their use. These policies shall be approved by the licensor prior to the use of this type of restraint. These policies shall be posted in the facility, understood by all staff, explained to all parents or guardians, children, and referring agencies at the time of admission.

115.10(1) *Physicians orders.* Each administration of chemical restraint shall be specifically ordered by a physician who has personally examined the child. There shall not be standing orders for the use of chemical restraint.

115.10(2) *Monitoring.* The child shall be monitored continuously by a person trained and qualified to observe potentially adverse side effects.

115.10(3) *Authorization.* The administrator of a residential facility or a person designated by that officer shall authorize the request for the use of chemical restraint.

115.10(4) *Continual use of chemical restraint.* When a child in care requires chemical restraint on more than four occasions during any 30-day period, a secure facility shall hold an immediate meeting to discuss the appropriateness of the child's continued placement at the facility.

This rule is intended to implement Iowa Code section 237.4.

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CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES FOR MENTALLY RETARDED CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 116]
[Prior to 2/11/87, Human Services[498]]

441—116.1(237) Applicability. This chapter relates specifically to the licensing and regulation of residential facilities serving mentally retarded children. Refer to 441—Chapter 112 for basic licensing and regulation of all foster care facilities, 441—Chapter 114 for definitions and minimum standards for all group living foster care facilities, including community care facilities, and 441—Chapter 115 for definitions and standards for comprehensive residential facilities for children. Chapters 112 and 114 apply to community residential facilities for mentally retarded children and Chapters 112, 114 and 115 apply to comprehensive residential facilities for mentally retarded children with the exception of the areas discussed specifically in this chapter.

This rule is intended to implement Iowa Code chapter 237.

441—116.2(237) Definitions.

"Community residential facility for mentally retarded children" means a community residential facility as defined in rule 441—114.2(237) which serves children who meet the definition of mentally retarded as defined in Iowa Code chapter 222.

"Comprehensive residential facility for mentally retarded children" means a comprehensive residential facility as defined in rule 441—115.2(237) which serves children who meet the definition of mentally retarded as defined in Iowa Code chapter 222.

"Direct-service provider" means any employee of an agency whose primary responsibility is the care and programming of the children through direct interactions. The definition of "child care worker" in rule 441—114.2(237) and all other references to child care workers shall be replaced by this definition and the term "direct-service providers" when reading the other applicable rule chapters.

"Indirect-service provider" means an employee of an agency who supervises, coordinates and administers employees and program components. The definitions of "caseworker" and "casework supervisor" in rule 441—114.2(237) and all other references to caseworkers or casework supervisors shall be replaced by this definition and the term "indirect-service providers" when reading the other applicable rule chapters.

This rule is intended to implement Iowa Code section 237.1.

441—116.3(237) Qualifications of staff.

116.3(1) *Direct-service providers.* Direct-service providers shall be paraprofessionals or professionals meeting all of the following criteria:

a. Paraprofessionals shall:

(1) Be at least 18 years of age.

(2) Have graduated from high school or earned a high school equivalency degree.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

b. Professionals in the direct-service provider category shall:

(1) Be at least 18 years of age.

(2) Have a bachelor of arts degree in a related field; or an associate of arts degree in a related field and two years experience specific to the job responsibilities; or two years of higher education in a related field and two years' experience specific to job responsibilities; or four years' experience in programming specific to job responsibilities.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

116.3(2) *Indirect-service providers.* Indirect-service providers shall meet one of the following education and experience criteria:

a. Have a master's in social work or a master of arts degree in a related field and one year of experience specific to job responsibilities.

b. Have a bachelor of arts degree in a related field and two years' experience specific to job responsibilities.

c. Have an associate of arts degree in a related field and four years' experience specific to job responsibilities.

d. Have five years' specific treatment program experience relating to the job responsibilities.

This rule is intended to implement Iowa Code section 237.3.

441—116.4(237) Staff to client ratio. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to four staff to client ratio during prime programming time.

This rule is intended to implement Iowa Code section 237.3.

441—116.5(237) Program components. In addition to the requirements of 441—subrule 114.8(3), the facility shall define in writing who is responsible for overseeing personal hygiene of children and maintaining general orderliness of the facility.

This rule is intended to implement Iowa Code section 237.3.

441—116.6(237) Restraint. In addition to the provisions of 441—Chapters 114 and 115, a restraint may be used as stated in the child's individual care plan as approved by the parent or guardian, caseworker, and facility as long as that facility meets the standards for utilizing that particular type of restraint.

This rule is intended to implement Iowa Code section 237.4.

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CHAPTER 117
FOSTER PARENT TRAINING

PREAMBLE

These rules describe required foster parent orientation, preservice training and in-service training. Their purpose is to ensure that the training and orientation are effective in preparing foster parents for their role.

These rules also describe the standards for training and orientation and the procedure to be approved as a training provider.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.1(237) Required preservice training. Foster parent preservice training shall be offered by the department or by a licensed child-placing agency through a training program that has been approved by the department pursuant to rule 441—117.5(237).

117.1(1) *Preservice training requirement.* Each individual foster parent applicant shall complete the entire "Partnering for Safety and Permanence: Model Approach to Partnership in Parenting" (PS-MAPP) curriculum developed by the Child Welfare Institute.

a. Applicants shall complete PS-MAPP training before receiving a license for the first time.

b. Applicants shall retake PS-MAPP if they do not complete the curriculum within 24 months after initially commencing it.

c. The department may waive the PS-MAPP training requirement in whole or in part when the department finds that:

(1) The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

(2) There is good cause for the waiver based upon the circumstances of the child and the applicant.

117.1(2) *Preservice training program approval requirements.*

a. *Content.* The program shall be designed to assist prospective foster parents in developing the understanding and abilities that are essential to promote children's safety, permanence, and well-being. The program shall address the following topics:

(1) Children in foster care, their needs and rights.

(2) Families of children in foster care, their rights and responsibilities.

(3) Caseworkers and their role.

(4) Foster parents, their motivation and role.

(5) Self-assessment of foster parent's strengths.

(6) The team effort of foster parents and caseworkers.

(7) The impact of foster care placement on the child, the child's family and the foster family.

(8) The purpose and importance of the child's contact with the child's family.

(9) Training in communication and behavior management.

(10) Permanency planning.

(11) The reasons for placement termination and feelings involved.

b. *Length.* The entire PS-MAPP program shall total at least 30 hours of contact between leaders and participants. The department's recruitment and retention contractor shall devise a procedure for applicants to make up any portions of training which are missed.

c. *Instructors.* The program shall be team taught by at least one foster or adoptive parent and one casework staff person. All instructors shall be certified PS-MAPP leaders.

d. *Group method.* The program shall be provided in groups that consist of six or more persons. The training shall be offered to a foster family individually only when the foster family is unable to attend group training for reasons such as serious medical conditions, as approved by the social work administrator or designee.

e. *Training certificate.* A certificate of completion shall be provided to each foster parent who completes the training.

f. *Training evaluation.* A means for participants in the training to evaluate the instructors and the content shall be provided.

g. *Training records.* A record of the applicants who begin and complete the training and of the training program evaluations shall be submitted to the recruitment and retention contractor at the end of each 30-hour PS-MAPP session.

117.1(3) *Universal precautions.* Before licensure, each individual foster parent shall complete one hour of training related to the use and practice of universal precautions. Training shall be completed through the approved individual self-study course, "Universal Precautions in Foster and Adoptive Resource Family Homes."

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.2(237) Required orientation. All foster parent applicants shall attend orientation before attending PS-MAPP training and before a foster child is placed in their home. Orientation shall not count toward the required 30 hours of preservice training.

117.2(1) *Method of provision.* The recruitment and retention contractor may provide orientation:

a. In an individual meeting with one set of foster parent applicants; or

b. In a group setting.

117.2(2) *Provider.* Orientation shall be provided by the recruitment and retention contractor completing the family's licensing study.

117.2(3) *Content.* Orientation shall be designed to provide the foster parent applicant with information on the policies and procedures of the foster care and adoption programs and shall include the following:

a. Process and procedures for placement and termination of placement.

b. Medical assistance program information.

c. Foster family reimbursement information and adoption subsidy information if applicable.

d. Child abuse law and child abuse investigation procedures.

e. Confidentiality.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.3(237) Application materials for in-service training. Applications for approval of an in-service training program shall be submitted on Form 470-2541, Foster Parent Training Application, and must be approved before the delivery of the training. Applications submitted after a training is completed shall not be approved.

117.3(1) Except for cardiopulmonary resuscitation and first-aid training, foster parent in-service training shall meet the requirements in rule 441—117.7(237).

117.3(2) Applications shall be submitted with the following materials:

a. A detailed training program description relative to a foster parent, including objectives, program agenda, content, participant materials, and time frames.

b. Names of program instructors and their qualifications to provide the training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.4(237) Application process for in-service training.

117.4(1) *Group training.* Applications to provide group foster parent training shall be submitted to the department office for the service area in which the training will be conducted.

117.4(2) *Individual training.* Applications for approval for individual training, college credit, written materials, DVDs or videotapes shall be submitted to the department office for the service area in which the foster family resides.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.5(237) Application decisions. The department shall notify the applicant of its decision regarding the application for approval of in-service training within 30 days of receipt of the training materials described in rule 441—117.3(237). This notification shall include the reason for not giving approval if approval is denied.

117.5(1) *Approval.* Foster parent training programs which meet the criteria in rule 441—117.1(237) or in rule 441—117.7(237) and which are submitted pursuant to rules 441—117.3(237) and 441—117.4(237) shall be approved by the department. In-service training completed before the program has received department approval shall not count toward the required six credit hours of in-service training. In-service training approvals are valid for one year.

117.5(2) Rescinded IAB 8/9/89, effective 10/1/89.

117.5(3) *Denial.* Preservice training programs which do not meet the requirements in rules 441—117.1(237), 117.3(237), and 117.4(237) and in-service training programs which do not meet the criteria in rules 441—117.3(237), 117.4(237) and 117.7(237) shall be denied approval. The applicant may submit a revised program for approval at a later date.

117.5(4) *Revocation.* Approval shall be revoked when any of the following exist and corrective action is not taken to correct the deficiencies within 45 days.

a. The training provider fails to provide the training as described in the approved application materials.

b. Over 25 percent of the participant evaluations of the training program rate the training program as not helpful.

If approval is revoked, the training provider may submit a revised program at a later date.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.6(237) Application conference available. If an applicant or provider of training objects in writing within seven days after the notification of the department's decision to deny approval, the area social work administrator shall review the decision to determine if the original decision shall stand. The decision of the area social work administrator is final and is not subject to appeal.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.7(237) Required in-service training. Training is required to assist foster parents in confidently and effectively addressing the needs of children placed in foster care. The Foster Parent Training Plan, Form 470-3341, shall be used to address in-service training needs. The training plan shall be developed with the department or retention and recruitment contractor and the foster parent at annual licensing renewal.

117.7(1) *Providers of in-service training.* Foster parent in-service training may be provided by the department, a licensed child-placing or child-caring agency, or an agency, institution, or association with expertise in the training content. Agencies, institutions, or associations wishing to have a foster parent in-service training program or workshop approved shall submit application materials pursuant to rules 441—117.3(237) and 441—117.4(237).

117.7(2) *In-service training program approval requirements.*

a. *Content.* The program shall relate to the foster parent's role in providing foster care and the skills needed by a foster parent. Training shall be specific to developing each foster parent's skills for addressing the needs of foster children.

b. *Method.* The training shall be provided through one or more of the following methods:

(1) Face-to-face training to a group.

(2) Face-to-face training to an individual foster family.

(3) Written materials.

(4) DVDs or videotapes.

(5) Internet training classes offered through the Iowa Foster and Adoptive Parents Association (IFAPA).

(6) Internet training classes offered through www.fosterparents.com, except for cardiopulmonary resuscitation and first-aid trainings, which are not approved.

c. *Credit hours.* Credit hours for approved training shall be as follows:

(1) Group training shall receive one credit hour for each face-to-face contact hour.

(2) Written materials shall receive one credit hour for each 100 pages.

(3) DVDs or videotapes shall receive one credit hour for each two program hours.

(4) College courses shall receive one credit hour for each college credit hour.

(5) Internet training classes shall receive one credit hour for each program hour. A maximum of three hours of training credit per year may be earned through the Web site www.fosterparents.com.

d. Approved training. The following training programs shall be considered as meeting the in-service training requirements:

(1) Workshops offered at the Iowa Association of Foster and Adoptive Parents' annual state conference.

(2) Workshops offered at the National Foster Parent Association's annual conference.

(3) Rescinded IAB 8/9/89, effective 10/1/89.

117.7(3) *Foster parent training requirements.* Each individual foster parent shall complete six credit hours of department-approved in-service training annually. Failure to meet the requirement for in-service training hours will result in denial of the license renewal.

a. Training cycle. "Annually" means within the annual training cycle as described in this paragraph.

(1) Initial license. For a newly licensed foster parent, the initial training cycle shall be the 10-month period ending 2 months before the license expires. EXAMPLE: The initial training cycle for a new license effective June 1 is June 1 through March 31.

(2) Renewal license. For a one-year license renewal, the annual training cycle shall be the 12-month period beginning 2 months before the expiration of the previous license and ending 2 months before the expiration of the subsequent license. EXAMPLE: The training cycle for a license effective June 1 would be April 1 through March 31 of the subsequent year. For a two-year license renewal, the training cycle for the first year shall be the 12-month period beginning 2 months before the expiration of the previous license year and ending 10 months after the effective date of the two-year license. The annual training cycle for the second year of a two-year license shall be the 12-month period beginning 11 months after the effective date of the first year of the license and ending 2 months before the expiration of the license.

b. Content. The choice of in-service training shall be based upon an assessment of the foster parent's training needs made by the foster parent and the recruitment and retention contractor in collaboration with the department licensing worker.

(1) Each foster parent must complete the specific training required in rule 441—117.8(237).

(2) At least three credit hours of the annual training shall be group training.

(3) Except for the classes for mandatory reporters, cardiopulmonary resuscitation, and first aid, training credit will not be allowed for any in-service training class that is repeated.

c. Documentation. Each individual foster parent shall submit Form 470-2540, Foster Parent Training Report, to the recruitment and retention contractor within 30 days after completion of each in-service training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12]

441—117.8(237) Specific in-service training required.

117.8(1) *Medication management.* Within the initial training cycle, each individual foster parent shall complete one hour of training related to the use and practice of medication management.

a. Training shall be completed through the approved individual self-study course, "Medication Management."

b. One hour of in-service training credit shall be allowed for completion of this self-study course. This course cannot be repeated for in-service training credit.

c. Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

117.8(2) *Cardiopulmonary resuscitation (CPR).* All foster parents shall be certified in CPR every three years and shall maintain a certificate indicating the date of training and expiration.

a. The training shall be provided by:

(1) A nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid), or

(2) An equivalent certified trainer and curriculum approved by the department.

b. Newly licensed foster parents shall complete the training before the end of their initial training cycle. Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

117.8(3) *First aid.* All foster parents shall be certified in first aid every three years and shall maintain a certificate indicating the date of training and expiration. Newly licensed foster parents shall complete the training before the end of their initial training cycle. Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

117.8(4) *Child abuse reporting.* Each foster parent shall complete approved training relating to the identification of child abuse and requirements and procedures for the reporting of child abuse pursuant to Iowa Code section 232.68.

a. *Training cycle.* Newly licensed foster parents shall complete mandatory reporter training before the end of their initial training cycle. The training shall be repeated every five years thereafter.

b. *Training provider.* The foster parent shall be responsible for obtaining the required two-hour mandatory reporter training in child abuse identification and reporting as approved by the Iowa department of public health. A list of approved training opportunities is available at: http://www.idph.state.ia.us/bh/abuse_ed_review.asp.

c. *Documentation.* The foster parent shall secure documentation of the training content, amount, and provider and shall forward the documentation to the recruitment and retention contractor, who will provide the documentation to the department for inclusion in the foster parent's licensing file.

117.8(5) *Caring for children with HIV.* Before placement of an HIV-infected child occurs, the foster parents shall complete the course "Caring for Children With HIV" or an approved alternative course that contains information on the unique aspects of pediatric HIV disease, transmission and infection control, the spectrum of HIV disease, confidentiality, death and bereavement, and self-care for the caregiver.
[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.9(237) Foster parent training expenses. No expense stipend is provided for orientation or preservice training.

117.9(1) *Training stipend.* Each family that is issued an initial or renewal foster family home license shall receive a $100 stipend to be used for the family's annual in-service training. The department's recruitment and retention contractor shall issue one stipend per license on or after the date that the license is issued. When a family with a two-year foster family home license has completed the first training cycle of six hours of in-service training, the contractor shall issue the next training stipend no earlier than the start of the second year of licensure contingent upon the foster family's completion of the in-service training hours in the first cycle. Foster families who elect not to receive the $100 stipend shall notify the department.

117.9(2) *Trainer fees.* Foster parents and social workers who serve as trainers for approved preservice training programs shall each be paid a contract fee per class hour appropriate to community standards based upon the education and experience of each trainer. These rates shall be negotiated between the recruitment and retention contractor and the trainer.
[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12]

These rules are intended to implement Iowa Code section 237.5A.

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CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

PREAMBLE

This chapter establishes rules for the child care quality rating system, which is designed for child care programs that primarily serve children between birth and the age of 12. Participation in the quality rating system is voluntary. The chapter includes application procedures and standards for the quality rating.
[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.1(237A) Definitions.

"Aim4Excellence credential" means the national director credential for early childhood administrators that is administered by the McCormick Center for Early Childhood Leadership.

"Apprenticeship certificate" means a nationally recognized Child Care Development Specialist Registered Apprenticeship Certificate awarded by the U.S. Department of Labor. The certificate requires two years of full-time employment with on-the-job training and 288 hours (at least 19 credits) of approved, related college education or training.

"Child care facility" means a licensed child care center, a preschool, or a registered child development home.

"Child care nurse consultant" means a registered nurse licensed in the state of Iowa who has completed training using a nationally approved curriculum for health and safety in child care and early education. The child care nurse consultant provides on-site consultation, technical assistance, and training to child care and early education providers regarding health and safety. The child care nurse consultant is employed by or has a written agreement with the local Title V maternal and child health agency or contracts for service delivery directly through the state-level Title V maternal and child health program administered by the Iowa department of public health, bureau of family health.

"Child development associate credential (CDA)" means a credential awarded by the Council for Professional Recognition to individuals working in child care settings who demonstrate proficiency in specific competency standards. The credential requires 120 hours of approved training over the past five years.

"ChildNet certification" means verified completion of the 25-hour ChildNet training series in areas specifically designed for child development home providers and completion of the certification process.

"Department" means the department of human services.

"Eligible applicants" means programs meeting the definition of "child care facility" or programs operating under the authority of an accredited school district or nonpublic school.

"Environment rating scale" means a child care program assessment instrument (scale) developed through the auspices of the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill. The scale is the measurement tool used by an assessor during an on-site observation of a child care classroom to evaluate and provide a score to a child care program. Scales must be administered by entities approved by the department of human services or the department's designee. Four scales are available, based on the type of program being assessed:

1. Family child care environment rating scale for programs conducted in a provider's own home for children from infancy through school age.
2. Infant/toddler environment rating scale for group programs for children from birth to 2½ years of age.
3. Early childhood environment rating scale for group programs for children of preschool through kindergarten age, 2½ to 5 years.
4. School-age care environment rating scale for group programs for children of school age, 5 to 12 years.

"Head Start program performance standards" means the standards that define the services that Head Start programs are required to provide to the children and families they serve. The standards constitute the expectations and requirements that Head Start grantees must meet.

"Iowa quality preschool program standards" means standards developed by the Iowa department of education, based on the ten standards of the National Association for the Education of Young Children accreditation.

"National administrator credential (NAC)" means the 40-hour comprehensive training for child care and education administrators and successful completion of the certification process.

"Staff in the classroom" means staff responsible for care of children in the classroom.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.2(237A) Application for quality rating. Eligible applicants shall apply for a quality rating by submitting the specified application form and any required supporting documentation to the department. Applications for a Level 1 rating will not be accepted from programs that have previously been rated at Level 1.

118.2(1) *Transition period.* For the period February 1, 2011, through July 31, 2011, eligible applicants may apply for a quality rating either under this subrule or under subrule 118.2(2).

a. A child care center or preschool applying under this subrule shall complete Form 470-4229, Application for Quality Rating—Center/Preschool. The quality rating will be based on the standards in rule 441—118.3(237A).

b. A child development home applying under this subrule shall complete Form 470-4302, Application for Quality Rating—Child Development Home. The quality rating will be based on the standards in rule 441—118.4(237A).

118.2(2) *Ongoing standards.* Until August 1, 2011, eligible applicants have the choice of applying under this subrule or under subrule 118.2(1). Effective August 1, 2011, all eligible applicants must apply for a quality rating under this subrule.

a. A child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under this subrule shall complete Form 470-4902, Quality Rating System Application for Licensed Centers, Preschools, and School-Based Programs. The quality rating will be based on the standards in rule 441—118.5(237A).

b. A child development home applying under this subrule shall complete Form 470-4901, Quality Rating System Application for Child Development Homes. The quality rating will be based on the standards in rule 441—118.6(237A).

118.2(3) *Change in location of facility.* If the location of a rated program changes, the program must notify the department and complete a new application form as specified in subrule 118.2(1) or 118.2(2). The department shall make a new determination of the appropriate rating.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child care center or preschool shall certify that its facility meets the applicable criteria as defined in subrule 118.3(1).

118.3(1) *Criteria.* Criteria for each rating level are defined as follows.

a. *Level 1.* To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department of human services with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. *Level 2.* To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department of human services with no action pending to revoke or deny the license, or operate under the authority of an accredited school district or nonpublic school.

(2) The facility must complete the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(3) The facility must complete the Iowa department of public health's provider health and safety questionnaire, Form HCCI-CDOS2006, Child Care Center Director/Owner Survey.

(4) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(5) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(6) The facility must provide basic orientation for all staff before they begin work.

(7) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. *Level 3.* To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 10 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 18 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 26 points from the categories listed in subrules 118.13(2) through 118.13(6).

(2) The facility must earn at least one point from each category.

118.3(2) *Professional development.* A child care center or preschool may earn a maximum of 12 points in the professional development category. Points are awarded as follows:

a. *Credential.* Two points are awarded if the facility director:

(1) Has a current national administrator credential; or

(2) Is a school principal licensed by the Iowa board of educational examiners.

b. *Related degree.* One point is awarded if at least one staff member at the facility has at least a bachelor's degree in education specific to the age group for whom the person provides care.

c. *Education and experience.* A facility may earn a maximum of nine points for staff education and experience. Programs may select up to two of the following options:

(1) Five points are awarded if at least 50 percent of staff in each classroom have a minimum of a bachelor's degree in education specific to the age group for whom they provide care.

(2) Four points are awarded if at least 50 percent of staff in each classroom have a minimum of an associate's degree in education specific to the age group for whom they provide care.

(3) Three points are awarded if at least 50 percent of staff in each classroom have a minimum of a child development associate credential or apprenticeship certificate.

(4) Two points are awarded if at least 50 percent of staff in each classroom have a minimum of either six college credit hours in education specific to the age group for whom they provide care or have a paraeducator certificate from the Iowa board of educational examiners.

(5) Two points are awarded if at least 50 percent of staff in each classroom have received a minimum of 30 hours of training beyond regulatory requirements in the last 12 months and have at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school.

(6) One point is awarded if at least 50 percent of staff in each classroom have received a minimum of 15 hours of training beyond regulatory requirements in the last 12 months.

118.3(3) *Health and safety.* A child care center or preschool may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. *Injury prevention.* A facility may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

b. *Child record review.* A facility may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

c. *Health and safety assessment.* A facility may earn a maximum of three points for health and safety assessment. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.3(4) *Environment.* A child care center or preschool may earn a maximum of 11 points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.*

(1) One point is awarded if the facility director or assistant director completes approved training on using the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes a self-assessment of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the appropriate environment rating scale.

(3) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

b. *Environment rating scale.* A facility may earn a maximum of three points on the environment rating scale. The facility director or assistant director must complete training on the use of one of the environment rating scales before requesting assessment. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility. Points are awarded as follows:

(1) One point is awarded if the facility receives an average score of 3 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(2) Two points are awarded if the facility receives an average score of 4 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(3) Three points are awarded if the facility receives an average score of 5 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

c. *Iowa quality preschool program standards.* A facility may earn a maximum of two points on the Iowa quality preschool program standards. Points are awarded as follows:

(1) One point is awarded if the facility completes training on Iowa quality preschool program standards.

(2) One point is awarded if the facility completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

d. *Accreditation.* A facility may earn a maximum of three points for accreditation. Points are awarded as follows:

(1) One point is awarded if the facility meets accreditation standards for group or class size from an accrediting body identified in subparagraph (2) that is appropriate to the child care setting.

(2) Three points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department of human services or if a Head Start program demonstrates compliance with Head Start program performance standards.

118.3(5) *Family and community partnerships.* A child care center or preschool may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents and holds annual conferences with parents.

118.3(6) *Leadership and administration.* A child care center or preschool may earn a maximum of four points in the leadership and administration category. Points are awarded as follows:

a. One point is awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops and updates Form 470-4235, Child Care Center Improvement Plan, annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. One point is awarded if all staff who have direct contact with children have a full, facility-based orientation within four months of beginning employment with the facility.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child development home provider shall certify that the home meets the applicable criteria as defined in subrule 118.4(1).

118.4(1) *Criteria for each rating level.*

a. To be rated at Level 1, the home must be a registered child development home.

b. To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(4) The provider completes the Iowa department of public health's provider health and safety questionnaire, Form HCCI-HDOS2006, Home Child Care Center Director/Owner Survey.

(5) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(6) The provider completes Form 470-4236, Professional Development Plan.

c. To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of seven points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

d. To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 12 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

e. To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 16 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

118.4(2) *Professional development.* A child development home may earn a maximum of six points in the professional development category. Points are awarded as follows:

a. *Experience and training.* A home may earn a maximum of two points for experience and training. Points are awarded as follows:

(1) One point is awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Two points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. *Education.* A home may earn a maximum of four points for education. Points are awarded as follows:

(1) Two points are awarded if the provider has completed an apprenticeship certificate, child development associate credential, or at least nine college credit hours in education specific to the age group for whom care is provided.

(2) Three points are awarded if the provider has completed an associate's degree in education specific to the age group for whom care is provided.

(3) Four points are awarded if the provider has completed a bachelor's degree or higher in education specific to the age group for whom care is provided.

118.4(3) *Health and safety.* A child development home may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. *Injury prevention.* A home may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

b. *Child record review.* A home may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has worked with the child care nurse consultant to refer families to health care providers.

c. *Health and safety assessment.* A home may earn a maximum of three points in the health and safety assessment category. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

118.4(4) *Environment.* A child development home may earn a maximum of eight points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.* A home may earn a maximum of three points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) One point is awarded if the provider completes approved training on how to use the family day care rating scale to assess the child development home environment.

(2) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes a self-assessment using the family day care rating scale.

(3) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the family day care rating scale self-assessment.

b. *Environment rating scale.* A home may earn a maximum of two points on the environment rating scale. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. The provider must complete training on the family day care rating scale before requesting assessment. Points are awarded as follows:

(1) One point is awarded if the home receives an average score of 4 on a scale of 7, with no subscale scores lower than 2.

(2) Two points are awarded if the home receives an average score of 5 on a scale of 7, with no subscale scores lower than 2.

c. *Accreditation.* Three points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department of human services.

118.4(5) *Family and community partnerships.* A child development home may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents and holds annual conferences with parents.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school. To participate in the quality rating system, a child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under subrule 118.2(2) shall certify that its facility meets the applicable criteria as defined in subrule 118.5(1).

118.5(1) *Criteria.* Criteria for each rating level are defined as follows:

a. *Level 1.* To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. *Level 2.* To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department with no action pending to revoke or deny the license or must operate under the authority of an accredited school district or nonpublic school.

(2) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(3) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(4) The facility must provide basic orientation for all staff before they begin work.

(5) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. *Level 3.* To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 17 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 27 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 34 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

(3) The facility must earn a minimum score of 5.0 in each assessed classroom on the appropriate environment rating scale. An assessor approved by the department or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility.

118.5(2) *Professional development.* A maximum of 30 points may be earned in the professional development category. Points are awarded as follows:

a. *Credential.* A maximum of five points may be earned in the credential category.

(1) Five points are awarded if the facility director has a current national administrator credential or Aim4Excellence credential.

(2) Five points are awarded if the facility director is a school principal licensed by the Iowa board of educational examiners.

(3) Five points are awarded if a staff member has completed the two-year Head Start management acceleration program covering all aspects of Head Start management, services and systems.

b. *Education and experience.* A maximum of 25 points may be earned for education and experience. To arrive at the total number of points earned, each staff member shall indicate the highest applicable education and experience qualification. Points will be assigned for each staff member based on the following criteria, and the total points will be divided by the number of staff. Only one criterion may be scored for each staff member.

(1) Has a master's degree in education appropriate to the age group for whom care is provided: 25 points.

(2) Has a bachelor's degree in education appropriate to the age group for whom care is provided: 20 points.

(3) Has an associate's degree in education appropriate to the age group for whom care is provided: 10 points.

(4) Has a one-year diploma in education appropriate to the age group for whom care is provided: 8 points.

(5) Has an apprenticeship certificate: 7 points.

(6) Has a child development associate credential: 6 points.

(7) Has an Iowa board of educational examiners paraeducator certificate at Level 2, early childhood, plus two years of experience in early childhood education under the supervision of a licensed early childhood teacher: 6 points.

(8) Has nine college credit hours in education specific to the age group for whom care is provided: 5 points.

(9) Has 30 hours of annual approved training beyond regulatory requirements and at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school: 4 points.

(10) Has 15 hours of annual approved training beyond regulatory requirements: 2 points.

118.5(3) *Health and safety.* A maximum of 19 points may be earned in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.5(4) *Environment.* A maximum of 27 points may be earned in the environment category. Points are awarded as follows:

a. *Training and self-assessment.* A maximum of nine points may be earned in training and self-assessment.

(1) Two points are awarded if the facility director or assistant director completes approved training on the use of the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes a self-assessment and score sheet of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the applicable environment rating scale.

(3) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

(4) Three points are awarded if, after completing approved training on Iowa quality preschool program standards, the facility director or assistant director completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

b. *Enhanced ratios.* A facility may earn a maximum of three points for enhanced staff-to-child ratios. Three points are awarded if the facility meets accreditation standards for group or class size and staff-to-child ratio from an accrediting body identified at subparagraph 118.5(4)*"d"*(3) that is appropriate to the child care setting. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

c. *Accreditation preparation.* A facility may earn a maximum of five points for accreditation preparation. Five points are awarded if the facility's accreditation self-assessment is approved by the National Association for the Education of Young Children. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

d. *Accreditation.* A facility may earn a maximum of 18 points for accreditation. Points are awarded for one of the following criteria:

(1) Five points are awarded if the program is verified by the Iowa quality preschool program standards.

(2) Six points are awarded if a Head Start program demonstrates compliance with Head Start program performance standards.

(3) Eighteen points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department.

118.5(5) *Family and community partnerships.* A maximum of eight points may be earned in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents.

c. One point is awarded if the facility holds annual conferences with parents.

d. One point is awarded if the facility holds at least one parent meeting annually.

e. Two points are awarded if a parent advisory board coordinated by the facility meets quarterly.

f. Two points are awarded if the facility collects annual parent surveys and uses the results to inform program practices.

118.5(6) *Leadership and administration.* A maximum of seven points may be earned in the leadership and administration category. Points are awarded as follows:

a. Two points are awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops an improvement plan using Form 470-4235, Child Care Center Improvement Plan, and updates the form annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. Three points are awarded if all staff who have direct contact with children complete one of the following within four months of beginning employment with the facility:

(1) The new staff orientation training delivered by Iowa state university that provides new center and preschool staff a full, program-based orientation, or

(2) Another curriculum approved by the department.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.6(237A) Rating criteria for child development homes. To participate in the quality rating system, a child development home provider applying under subrule 118.2(2) shall certify that the home meets the applicable criteria as defined in subrule 118.6(1).

118.6(1) *Criteria for each rating level.*

a. *Level 1.* To be rated at Level 1, the home must be a registered child development home.

b. *Level 2.* To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(4) The provider completes Form 470-4236, Professional Development Plan.

c. *Level 3.* To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 14 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 19 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 25 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

(3) The home must earn a minimum score of 5.0 on the family child care environment rating scale. An assessor approved by the department or the department's designee must perform the assessment.

118.6(2) *Professional development.* A child development home may earn a maximum of 34 points in the professional development category. For child development homes registered as Category C, points will be awarded only to the coprovider who has earned the most points. Points are awarded as follows:

a. *Experience and training.* A home may earn a maximum of four points for experience and training. Points are awarded as follows:

(1) Two points are awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Four points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. *Additional professional development.* A home may earn a maximum of five points for additional professional development. Points are awarded as follows:

(1) Two points are awarded if the provider successfully completes approved modules 1 and 2 of positive behavior and intervention support training developed by the Center on Social and Emotional Foundations for Learning (CSEFEL). Modules 1 and 2 total a minimum of 12 hours of training which focuses on promoting effective classroom and center practices that enhance the social and emotional competency of young children.

(2) Three points are awarded if the provider successfully completes modules 1 through 4 of the program for infant and toddler care developed by WestEd and the California Department of Education, covering social-emotional growth and socialization, group care, learning and development, culture, and family and providers.

c. *Education.* A home may earn a maximum of 25 points for education. Points are awarded for one of the following criteria:

(1) Twenty-five points are awarded if the provider has completed a master's degree in education appropriate to the age group for whom care is provided.

(2) Twenty points are awarded if the provider has completed a bachelor's degree in education appropriate to the age group for whom care is provided.

(3) Ten points are awarded if the provider has completed an associate's degree in education appropriate to the age group for whom care is provided.

(4) Eight points are awarded if the provider has completed a one-year diploma in education appropriate to the age group for whom care is provided.

(5) Seven points are awarded if the provider has a current apprenticeship certificate.

(6) Six points are awarded if the provider has a current child development associate credential.

(7) Five points are awarded if the provider has completed at least nine college credit hours in education specific to the age group for whom care is provided.

118.6(3) *Health and safety.* A child development home may earn a maximum of 19 points in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the provider successfully completes a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the provider successfully completes a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.6(4) *Environment.* A child development home may earn a maximum of 23 points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.* A home may earn a maximum of six points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) Two points are awarded if the provider completes approved training on how to use the family child care environment rating scale to assess the child development home environment.

(2) Two points are awarded if, after completing training on how to use the environment rating scale, the provider completes a self-assessment and score sheet using the environment rating scale.

(3) Two points are awarded if, after completing training on how to use the environment rating scale and completion of the environment rating scale self-assessment and score sheet, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the environment rating scale self-assessment.

b. *Enhanced ratios.* A home may earn a maximum of two points for enhanced staff-to-child ratios. Two points are awarded if no more than two children under the age of two are in care at any one time

and no more than six children total are in care at any one time, including the provider's own children under school age.

c. *Accreditation.* A home may earn a maximum of 15 points for accreditation. Fifteen points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department.

118.6(5) *Family and community partnerships.* A child development home may earn a maximum of six points in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents.

c. One point is awarded if the provider holds annual conferences with parents.

d. One point is awarded if the provider holds at least one parent meeting annually.

e. Two points are awarded if the provider collects annual parent surveys and uses the results to inform program practices.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.7(237A) Award of quality rating.

118.7(1) The facility shall display Form 470-4230, Quality Rating Certificate, in a conspicuous place.

118.7(2) Achievement bonuses may be awarded as funds are available.

118.7(3) Participants may request another quality rating for the purpose of increasing their rating no sooner than 12 months after issuance of a quality rating certificate.

118.7(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.8(237A) Adverse actions.

118.8(1) An eligible applicant must be notified of the right to appeal the rating decision in accordance with 441—Chapter 7.

118.8(2) A participant's quality rating shall be revoked if the facility no longer meets the definition of "eligible applicants."

118.8(3) Form 470-4230, Quality Rating Certificate, shall be returned to the department of human services if:

a. The certificate is revoked;

b. The certificate is not renewed; or

c. The provider voluntarily withdraws from the program.

118.8(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

These rules are intended to implement Iowa Code section 237A.30.

[Filed 11/16/05, Notice 9/14/05—published 12/7/05, effective 2/1/06]

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CHAPTER 119
RECORD CHECK EVALUATIONS FOR CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

PREAMBLE

These rules establish procedures for the performance of record check evaluations by the department of human services for personnel employed by health care facilities and other programs and for students in educational training programs for nurses and certified nurse aides. Record check evaluations are performed, at the request of a prospective employer or training program, on persons who have been found to have been convicted of a crime under a law of any state or have a record of founded child or dependent adult abuse, to determine whether the crimes or founded abuses warrant prohibition of employment or enrollment in a training program.

[**ARC 0486C**, IAB 12/12/12, effective 2/1/13]

441—119.1(135B,135C) Definitions.

"Department" means the department of human services.

"Requesting entity" means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can be employed by the entity or participate in an educational training program and includes the following:

1. Health care facilities as defined in Iowa Code section 135C.1.
2. Programs in which the provider is regulated by the state or receives any state or federal funding and the employee being evaluated provides direct services to consumers including but not limited to programs that employ homemakers or home health aides, programs that provide adult day services, hospices, federal home- and community-based services waiver providers, elder group homes, and assisted living programs.
3. Substance abuse programs for juveniles as described in Iowa Code section 125.14A.
4. Hospitals as defined in Iowa Code section 135B.1.
5. Psychiatric medical institutions for children as defined in Iowa Code section 135H.1.
6. The department as described in Iowa Code section 217.44.
7. Department institutions as defined in Iowa Code section 218.13.
8. Child foster care facilities as defined in Iowa Code section 237.1.
9. Medicaid home- and community-based services waiver providers as defined in Iowa Code section 249A.29.
10. Certified nurse aide training programs as defined in Iowa Code section 135C.33(8).
11. Nursing training programs as described in Iowa Code chapter 152.

[**ARC 0486C**, IAB 12/12/12, effective 2/1/13; **ARC 1263C**, IAB 1/8/14, effective 3/1/14]

441—119.2(135B,135C) When record check evaluations are requested.

119.2(1) *Record check evaluations on prospective employees and students.* A requesting entity shall request a record check evaluation prior to employment or enrollment of a person whose background check indicates a criminal or dependent adult abuse or child abuse record. Criminal, child abuse and dependent adult abuse background checks are required on all prospective employees or students, including employees or students who have terminated employment or participation in a training program for any reason or any length of time and wish to return to the same employment or training program, unless an exemption is provided in these rules.

a. A hospital or licensee of a health care facility may employ a person for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

(1) The employment does not involve operation of a motor vehicle; and

(2) The person to be employed has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and

(3) The person to be employed does not have a record of founded child or dependent adult abuse; and

(4) The hospital or licensee has requested an evaluation.

b. A training program in a facility licensed under Iowa Code chapter 135C may allow a student who is applying for, enrolled in, or returning to a certified nurse aide training program to participate in the clinical education component of the training program for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

(1) The student's clinical education component of the training program involves children or dependent adults; and

(2) The program does not involve operation of a motor vehicle; and

(3) The student has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and

(4) The student does not have a record of founded child or dependent adult abuse; and

(5) The training program has requested an evaluation.

119.2(2) *Record check evaluations on current employees and students.* A requesting entity shall request a record check evaluation on current employees and students when a current employee or student background check indicates a criminal conviction (other than an Iowa Code chapter 321 simple misdemeanor or equivalent simple misdemeanor offense from another jurisdiction) or dependent adult or child abuse record and the requesting entity intends to continue to employ the employee or to continue the student's enrollment in a training program. The requesting entity shall request a current criminal or dependent adult or child abuse record check when the entity receives credible information as determined by the entity that a current employee or student has a criminal or dependent adult or child abuse record that has not been previously considered by the requesting entity.

119.2(3) *Transfer of employee between facilities.* If a person owns or operates more than one facility, and an employee of one of the facilities is transferred to another facility without a lapse in employment, the facility is not required to request additional criminal or abuse record checks of the employee or obtain a new record check evaluation.

119.2(4) *Exceptions to record check evaluation requirements for employment under Iowa Code chapter 135B or 135C or participation in a training program in facilities licensed under Iowa Code chapter 135C.* If an evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment, the person who is or was employed by a hospital licensed under Iowa Code chapter 135B and is hired by another hospital or the person who is or was employed by a facility licensed under Iowa Code section 135C.33 and is hired by another facility licensed under Iowa Code section 135C.33 may commence employment without further action by the department subject to the following conditions:

a. The record check performed by the subsequent employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

b. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

c. Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

d. The person subject to the record checks has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a new record check evaluation shall be performed.

e. Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

f. The subsequent employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

119.2(5) *Exceptions to record check evaluation requirements for new employees under Iowa Code chapter 135B or 135C or participants in a training program in facilities licensed under Iowa Code chapter 135C.* If the person approved for employment or participation does not start employment or attend the training program, as defined in subrule 119.4(3), within 30 days from the notice of decision approving the person, the requesting entity must perform a new record check.

a. If the evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment or participation in a training program, the person being considered for employment may commence employment without further action by the department subject to the following conditions:

(1) The record check performed by the employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

(2) The position with the employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

(3) Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

(4) The employer or person subject to the record checks has maintained a copy of the previous evaluation. If a physical copy of the previous evaluation is not maintained, a new record check evaluation shall be requested.

(5) Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

(6) The employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

b. If the record check indicates that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation, a new record check evaluation shall be performed.

c. Record check evaluations completed in accordance with paragraph 119.4(3)*"c"*are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.

[**ARC 0486C**, IAB 12/12/12, effective 2/1/13; **ARC 1263C**, IAB 1/8/14, effective 3/1/14]

441—119.3(135C) Request for evaluation.

119.3(1) *Required documentation.* The requesting entity and the prospective employee or student shall complete and submit the record check evaluation form to the department to request an evaluation. The requesting entity shall submit the form and required documentation to the Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, Iowa 50305-4826. The department shall not process evaluations that are not signed by the prospective employee or student. The position sought or held must be clearly written on the first page of the record check evaluation form. The form shall be accompanied by the following documents:

a. A copy of the documentation of the person's status on the DCI criminal history database generated within 30 days of the date on which the request for evaluation is submitted to the department.

b. A copy of the Iowa criminal history data, if there is a history, as provided to the requesting entity by the division of criminal investigation.

c. A copy of the documentation of the person's status on the dependent adult abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

d. A copy of the documentation of the person's status on the child abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

119.3(2) *Additional documentation.*

a. The requesting entity may provide or the department may request from the prospective employee or student or from the requesting entity information to assist in performance of the evaluation that includes, but is not limited to, the following:

(1) Documentation of criminal justice proceedings.

(2) Documentation of rehabilitation.

(3) Written employment references or applications.

(4) Documentation of substance abuse education or treatment.

(5) Criminal history records, child abuse information, and dependent adult abuse information from other states.

(6) Documentation of the applicant's prior residences.

b. Any person or agency that might have pertinent information regarding the criminal or abuse history and rehabilitation of a prospective employee or student may be contacted.

[**ARC 0486C**, IAB 12/12/12, effective 2/1/13; **ARC 1263C**, IAB 1/8/14, effective 3/1/14]

441—119.4(135B,135C) Completion of evaluation.

119.4(1) *Considerations.* The department shall consider the following when conducting a record check evaluation:

a. The nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held.

b. The time elapsed since the commission of the crime or founded child or dependent adult abuse.

c. The circumstances under which the crime or founded abuse was committed.

d. The degree of rehabilitation.

e. The likelihood that the person will commit a crime or founded child or dependent adult abuse again.

f. The number of crimes or instances of founded child or dependent adult abuse committed by the person involved.

119.4(2) *Evaluation conclusions.*

a. The department may determine the following:

(1) The person may be employed by the entity or enroll in the training program with no restrictions.

(2) The person may be employed by the entity or enroll in the training program with restrictions.

(3) The person may be employed by the entity or enroll in the training program with restrictions specific to a position within the program.

(4) The person may not be employed by the entity or enroll in the training program.

b. Restrictions on a person's employment or enrollment status shall be based upon what is necessary for the protection of the person or persons receiving care.

c. Medicaid waiver consumer-directed attendant care evaluations shall determine that either the person may work or the person may not work pursuant to Medicaid law.

119.4(3) *Notice of decision.* The department shall issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee or student.

a. The notice shall be valid only for employment with the employer or enrollment in a training program that requested the record check evaluation.

b. The notice shall not be valid for employment with any other prospective employer or enrollment in another training program.

c. Record check evaluations are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.

d. The notice of decision shall contain the notice of right to appeal.

[**ARC 0486C**, IAB 12/12/12, effective 2/1/13; **ARC 1263C**, IAB 1/8/14, effective 3/1/14]

441—119.5(135B,135C) Appeal rights. Any person or the person's attorney may file a written statement with the department requesting an appeal of the record check evaluation decision within 30 days of the date of the notice of the results of the record check evaluation in accordance with 441—Chapter 7.

[**ARC 1263C**, IAB 1/8/14, effective 3/1/14]

These rules are intended to implement Iowa Code section 135C.33.

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CHAPTERS 120 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

[Prior to 7/1/83, Social Services[770] Ch 130]
[Prior to 2/11/87, Human Services[498]]

441—130.1(234) Definitions.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or step mother or father, and children who reside in the same household.
3. An individual or a child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

This rule is intended to implement Iowa Code section 234.6.

441—130.2(234) Application.

130.2(1) Application for social services shall be made at any county office of the department of human services on forms available at the county office.

Application for services shall be made on Form 470-0615, Application for All Social Services.

130.2(2) The application may be filed by the applicant, the applicant's authorized representative, or where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

130.2(3) The date of application is the date a signed application form is received in the county office.

130.2(4) The application shall be approved or denied within 30 days from the date of application and the applicant notified of the decision. The decision shall be mailed or given to the applicant on the date the determination is made except that for services ordered by the court, the court order provided by the court and the case permanency plan provided by the department shall serve as notification. When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the application shall be approved or denied no later than the date that the department service manager, who is part of the interdisciplinary team, signs the individual program plan.

130.2(5) Eligibility shall be redetermined in the same manner as an application at least every 6 months for family-centered services. For all other services, eligibility shall be redetermined in the same manner as an application at least every 12 months.

130.2(6) Rescinded IAB 6/9/04, effective 7/1/04.

130.2(7) Rescinded IAB 6/9/04, effective 7/1/04.

130.2(8) Rescinded IAB 4/11/07, effective 7/1/07.

This rule is intended to implement Iowa Code section 234.6.

441—130.3(234) Eligibility.

130.3(1) Eligibility factors for services available through the department are individual need for a service and family income except when services are provided without regard to income or when services are directed in a court order.

a. Individual need is established when the service to be provided is directed at and will facilitate an individual in reaching or maintaining one of the goals and objectives in 130.7(1). Except when the court establishes need, the department shall do so in accordance with individual service chapters. The department shall determine the number of units to be provided.

b. The block grant service to be provided shall be contained in the pre-expenditure report and listed for the specific district and county. Service available through the department and funded by resources other than the social service block grant is identified in rules for that specific service.

c. Service shall be provided only when funds are available for service delivery.

d. Persons are financially eligible for services when they are in one of the following categories:

(1) Income maintenance status. They are recipients of the family investment program, or those whose income was taken into account in determining the needs of family investment program recipients,

or recipients of supplemental security income or state supplementary assistance, or those in the 300 percent group as defined in 441—subrule 75.1(7).

(2) Income eligible status. The monthly gross income according to family size is no more than the following amounts:

Monthly Gross Income Limits	
Family Size	
1 Member	$ 583
2 Members	762
3 Members	942
4 Members	1,121
5 Members	1,299
6 Members	1,478
7 Members	1,510
8 Members	1,546
9 Members	1,581
10 Members	1,612
11 Members	1,645
12 Members	1,678
13 Members	1,711
14 Members	1,744
15 Members	1,777
16 Members	1,810
17 Members	1,843
18 Members	1,876
19 Members	1,909
20 Members	1,942

(3) to (5) Rescinded IAB 6/9/04, effective 7/1/04.

e. Certain services are provided without regard to income which means family income is not considered in determining eligibility. The services provided without regard to income are information and referral, child abuse investigation, child abuse treatment, child abuse prevention services, including protective child care services, family-centered services, dependent adult abuse evaluation, dependent adult abuse treatment, dependent adult abuse prevention services, and purchased adoption services to individuals and families referred by the department.

f. In certain cases the department will provide services directed in a court order.

130.3(2) To be eligible for services the person must be living in the state of Iowa. Living in the state shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

130.3(3) In determining gross income, all income received by an individual from sources identified by the U.S. Census Bureau in computing median income is considered and includes money wages or salary, net income from nonfarm self-employment, net income from farm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, worker's compensation, alimony, child support; and veterans pensions. Excluded from the computation of monthly gross income are the following:

a. Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian claims commission or the court of claims.

b. Payments made pursuant to the Alaska Claims Settlement Act to the extent such payments are exempt from taxation under section 21(a) of the Act.

c. Money received from the sale of property, unless the person was engaged in the business of selling such property.

d. Withdrawals of bank deposits.

e. Money borrowed.

f. Tax refunds.

g. Gifts.

h. Lump sum inheritances or insurance payments or settlements.

i. Capital gains.

j. The value of the coupon allotment under the Food Stamp Act of 1964, as amended, in excess of the amount paid for the coupons.

k. The value of USDA donated foods.

l. The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act, as amended.

m. Earnings of a child 14 years of age or under.

n. Loans and grants obtained and used under conditions that preclude their use for current living expenses.

o. Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

p. Home produce utilized for household consumption.

q. Earnings received by any youth under Title III, Part C—Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973.

r. Stipends received by persons for participating in the foster grandparent program.

s. The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

t. Payments from the low-income home energy assistance program.

u. In determining eligibility for purchase of local services, one-third of the income of a disabled survivor who is a recipient of child's insurance benefits under the federal old-age, survivors, and disability insurance program established under Title II of the Federal Social Security Act.

v. In determining eligibility for purchase of local services, one-third of the income of a person who receives social security permanent disability benefits.

w. Agent Orange settlement payments.

x. Rescinded IAB 6/9/04, effective 7/1/04.

y. Rescinded IAB 6/9/04, effective 7/1/04.

z. Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

aa. Rescinded IAB 6/9/04, effective 7/1/04.

ab. Rescinded IAB 6/9/04, effective 7/1/04.

130.3(4) Rescinded IAB 8/9/89, effective 10/1/89.

130.3(5) Temporary absence. The composition of the family group does not change when one, or more, of the group members is temporarily absent from the household.

"Temporary absence" means:

a. A medical absence anticipated to be less than three months.

b. An absence for the purpose of education or employment.

c. When a family member is absent and intends to return home within three months.

130.3(6) Rescinded IAB 6/9/04, effective 7/1/04.

This rule is intended to implement Iowa Code section 234.6.

441—130.4(234) Fees. The department may set fees to be charged to clients for services received. The fees will be charged to those clients eligible under rule 130.3(234), but not those receiving services without regard to income due to a protective service situation. Nothing in these rules shall preclude a client from voluntarily contributing toward the costs of service.

130.4(1) *Collection.* The provider shall collect fees from clients. The provider shall maintain records of fees collected, and such records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment.

130.4(2) *Monthly income.* Rescinded IAB 1/8/92, effective 3/1/92.

130.4(3) *Child care services.* Rescinded IAB 6/9/04, effective 7/1/04.

130.4(4) Rescinded, effective 7/1/81.

This rule is intended to implement Iowa Code section 234.6.

441—130.5(234) Adverse service actions.

130.5(1) *Denial.* Services shall be denied when it is determined by the department that:

a. The client is not in need of service, or

b. The client is not financially eligible, or

c. The service to be provided is not in the Social Services Block Grant Pre-Expenditure Report, or

d. There is another community resource available to provide the service or a similar service free of charge to the client that will meet the client's needs, or

e. In cases other than protective service investigation, the client, parent, or representative refuses to sign the application form, or

f. The service for which the client is eligible is currently not available; a list of these services will be posted in each local office, or

g. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in each local office.

h. Rescinded IAB 8/9/89, effective 10/1/89.

i. Rescinded IAB 6/9/04, effective 7/1/04.

130.5(2) *Termination.* A particular service may be terminated when the department determines that:

a. The specific need to attain the goals and objectives to which the service was directed has been achieved, or

b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain the goals set forth in the individual client service plan, or

c. After repeated efforts, it is evident that the family or individual is unwilling to accept further service, or

d. The client's income or resources exceed the financial guidelines, or the client no longer meets other eligibility criteria established by the department for the service, or

e. The service is no longer offered or available from the department, or

f. No payment or partial payment of client fees has been received within 30 days following the issuance of the last billing, or

g. Another community resource is available to provide the service or a similar service free of charge to the client that will meet the client's needs, or

h. The client refuses to allow documentation of eligibility as to need, income, and resources, or

i. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in each local office.

j. The fee for case management services has not been paid within 30 days of the date on the second invoice sent by the department case management unit to the client. The second invoice shall be sent 30 days after the date of the first invoice if full payment of the fee has not been received.

130.5(3) *Reduction.* A particular service may be reduced when the department determines that:

a. Continued provision of service at its current level is not necessary. The department shall determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal. The client shall be notified of the decision.

b. Another community resource is available to provide the same or similar service to the client at no financial cost to the client, that will meet the client's needs.

c. Funding is not available to continue the service at the current level. The client shall be reassessed to determine the level of service to be provided.

d. Rescinded IAB 6/9/04, effective 7/1/04.

130.5(4) Rescinded, effective 6/1/84.

130.5(5) *Pending changes.* Workers shall endeavor to make clients aware of pending changes in services to be provided by social services block grant from one program year to the next, particularly for those services that will no longer be available. This requirement also applies to time-limited services.

130.5(6) *Inability of eligible cases to pay fees.* After billing or notification of termination and when the client reports in writing the inability to pay the fee due to the existence of one or more of the conditions set forth in the paragraphs below, and the worker assesses and verifies the condition, service shall be continued without fee until the condition no longer exists and the client is able to participate in the current fee for service. The worker shall assess all inability to pay cases to determine whether any case can be charged a reduced fee. The reduced fee shall then be charged until full participation in fees is possible.

a. Extensive medical bills for which there is neither payment through the medical assistance program, Title XVIII of the Social Security Act, nor other insurance coverage.

b. Shelter costs in excess of 30 percent of the household income.

c. Utility costs not including the cost of a telephone, in excess of 15 percent of the household income.

d. Rescinded 10/30/91, effective 11/1/91.

e. Additional expenses for food resulting from diets prescribed by a physician.

This rule is intended to implement Iowa Code section 234.6.

441—130.6(234) Social casework. For each active service case, when service is provided directly, purchased, or by a combination of methods, a department social worker shall:

130.6(1) Determine eligibility.

130.6(2) Ensure that there is a department case plan for each individual or family based on assessment of strengths and needs. Furnish appropriate sections of the initial plan and of all updated department case plans to the provider agency when services are purchased for an individual. When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the individual case management services provider shall distribute the case plans.

130.6(3) Refer the client to other workers or agencies through proper channels, and coordinate all workers involved in the case.

When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the individual case management services provider shall be responsible for making referrals and coordinating workers as specified in the individual program plan.

130.6(4) Enter information to the service reporting system.

130.6(5) Monitor the case to ensure that eligibility continues, services are received, plans are adjusted as needed, services reporting system reporting is correct, and the case is canceled when appropriate, according to these rules.

130.6(6) Ensure that services are unavailable elsewhere without cost to the client.

This rule is intended to implement Iowa Code section 234.6.

441—130.7(234) Case plan. The department worker shall develop a case plan with or on behalf of persons approved to receive services. However, a case plan is not required (1) for child or adult protective investigation, (2) for foster care cases in which the department does not have custody, guardianship or a voluntary placement agreement, or (3) when child care is the only service. A case plan shall be developed with or on behalf of every other person approved to receive services unless the person has a case manager as specified in 441—Chapter 24. When department services are provided before an

individual program plan in compliance with 441—Chapter 24 is approved, a department case plan must be developed according to the requirements of this rule.

When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the rules in 441—Chapter 24 on time limits, plan format and on who develops the plan shall apply for adults and for children whose services are not under court jurisdiction. The department worker shall determine eligibility for those services provided by the department; however, a separate department case plan need not be developed. If the individual program plan does not include sufficient information to meet department service requirements or the requirements in this chapter, the person providing department social casework shall complete either a case plan or addendum and coordinate distribution to the persons who receive the individual program plan with the case manager.

The case plan shall become part of the client's case record. The client shall participate in the development of this plan to the extent possible. The case plan shall be consistent with other service or program plans. A copy of the case plan shall be provided to the client or, when indicated, to the parent or representative of the client. For adult services, the case plan shall be recorded using Form 470-0583, Individual Client Case Plan. For children's services, the case plan shall be known as the case permanency plan and shall be prepared using Form 470-3453, Family Case Plan.

130.7(1) Services shall be directed toward the social services block grant goals of:

a. Achieving or maintaining self-support to prevent, reduce or eliminate dependency.

b. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.

c. Preventing or remedying neglect, abuse or exploitation of children or adults unable to protect their own interest, or preserving, rehabilitating or reuniting families.

d. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.

e. Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

130.7(2) The recorded case plan shall contain, but not be limited to, the following:

a. The goal and objective to which the plan is directed, stated in a clear manner indicating the specific services required to achieve or maintain the goals to meet the needs of the particular client.

b. Activities of clients, workers, and others involved in the plan related to specific services. These shall be measurable and have time frames for completion.

c. A summary of all pertinent information relating to the client and the client's situation relative to need, and containing, but not limited to, the following:

(1) Emotional behavior.

(2) Social aspects.

(3) Historical perspective.

(4) Reasons for success or lack of success.

(5) Safety-related information indicating whether a child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse. The safety-related information shall be withheld only if ordered by the court or the department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

(6) An assessment of whether continued breastfeeding by a child's mother is in the best interest of the child, and a plan to support the mother's breastfeeding efforts, if appropriate.

d. Information on case entries that will substantiate the client's eligibility for service.

e. A target date for reevaluation of the case plan based on assessment of need, which shall not exceed six months.

f. A review of financial eligibility in accordance with 130.2(5).

g. The reason for termination or reduction of any or all services.

h. Rescinded IAB 8/9/89, effective 10/1/89.

130.7(3) The case plan shall be developed and filed in the case record as follows:

a. In child welfare cases, the case plan shall be developed in partnership with the child, the family, and the caregiver.

(1) The recommendations from the child protective services assessment summary and the safety plan developed with the family shall be considered an initial case plan.

(2) A case plan that meets the requirements of Iowa Code section 232.2 shall be filed within 60 days from the date the child enters foster care or the date the department opens a child welfare service case, whichever occurs first.

b. For all other cases, the case plan shall be developed before services begin unless there is an unanticipated provision of service for the protection and well-being of a client. In that case, the case plan shall be filed within 45 days from the date that services begin.

130.7(4) The reevaluation of the case plan shall include all components listed under 130.7(2) and shall be filed at least every six months, or more often when there are significant changes, when required by the court, or when required according to the rules of the service.

130.7(5) The case plan may be amended between evaluation periods. Participants in the plan shall receive a copy of the amendment.

This rule is intended to implement Iowa Code section 234.6.

441—130.8 Monitoring and evaluation. Rescinded IAB 12/13/89, effective 2/1/90.

441—130.9(234) Entitlement. There is no automatic right to ongoing service in any service category from one fiscal year to the next.

This rule is intended to implement Iowa Code section 234.6.

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CHAPTER 131
SOCIAL CASEWORK

[Prior to 7/1/83, Social Services[770] Ch 159]
[Previously appeared as Ch 159—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—131.1(234) Definitions.

"Evaluate" means to periodically assess the appropriateness of services provided under the case plan (including social casework services) and to continue or terminate them as appropriate according to 441—Chapter 130 and the specific service chapters.

"Implement" means to arrange for the activities described in the case plan to begin and to advocate for the client when necessary so that services can begin.

"Social casework" means working with the client to:

1. Assess and identify individual and family strengths and needs,
2. Develop a case plan to provide appropriate supports and services,
3. Implement the case plan using community resources,
4. Coordinate and monitor the provision of services, and
5. Evaluate client progress and the case plan to determine continued need for services.

441—131.2(234) Eligibility. Social casework is provided to persons who meet the eligibility requirements for services as specified in rule 441—130.3(234).

441—131.3(234) Service provision. Social casework is provided directly by departmental staff.

441—131.4 Rescinded IAB 5/31/89, effective 8/1/89.

441—131.5(234) Adverse actions. Services shall be denied or terminated and appropriate notice given to clients as specified in rule 441—130.5(234).

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 132
STATE PAYMENT PROGRAM FOR SERVICES TO ADULTS

Rescinded IAB 7/8/92, effective 7/1/92

CHAPTER 133
IV-A EMERGENCY ASSISTANCE PROGRAM

PREAMBLE

This chapter defines and structures the department of human services' IV-A emergency assistance program. This program is designed to extend a menu of services to children who are victims or at risk of abuse or neglect, at risk of out-of-home placement, or in need of care or treatment. These rules define emergency assistance services as family-centered services, family preservation services, foster care, protective day care and wrap-around services. The rules further outline an application process, eligibility criteria, methods of service provision, and duration of service.

441—133.1(235) Definitions.

"Child" means a person under 18 years of age.

"Department worker" means the worker who is responsible for providing social casework as described in 441—Chapter 131.

"Emergency assistance" means any one or more of the following services provided in response to a IV-A emergency assistance application:

1. Family-centered child welfare services as set forth in 441—Chapter 172.
2. Shelter care as set forth in 441—Chapters 156 and 202, except for placements of less than 48 hours.
3. Protective child care as set forth in 441—Chapter 170.
4. Tracking, monitoring, and outreach as set forth in 441—Chapter 151, Division III.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or stepmother or stepfather, and children who reside in the same household.
3. An individual or child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—133.2(235) Application. An application for emergency assistance shall be made according to rule 441—130.2(234). An application shall be completed anytime a decision is made to provide emergency assistance or when an adult family member requests emergency assistance on behalf of a child.

133.2(1) The application shall be filed by a parent, except where both parents are absent or unwilling to apply on behalf of a child who meets all other eligibility conditions, in which case another adult member of the family with whom the child resides or has resided within the past six months acting on behalf of the child may file the application.

133.2(2) If the application is made on behalf of a child for whom the department has legal custody, the department worker may sign the application on behalf of the child.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—133.3(235) Eligibility. To be eligible for emergency assistance, the family shall meet all of the following criteria:

133.3(1) *Existence of an emergency.* An emergency situation shall exist. An emergency exists when one of the following situations exists:

a. Abuse, neglect, or abandonment of a child exists, or risk of same.

b. Children are in imminent danger where continued presence in the home is not in the best interests of the child.

c. Children have been removed from the home or are at risk of removal from the home because of abuse, neglect, which may include homelessness, or inability of parents to provide needed care or treatment or to control the behavior of the child.

133.3(2) *No refusal to accept employment or training.* The emergency situation did not arise out of an applicant's or applicant's family's refusal without good cause to accept employment or training for employment within 30 days of the date of the application.

133.3(3) *Residence.* The child is living, or within six months prior to the month in which assistance is requested has been living, with one or both parents, or a grandparent, adoptive parent, stepparent, sibling, aunt, uncle or cousin in a place of residence maintained as the child's own home.

133.3(4) *Service need.* The applicant must demonstrate a need for one or more of the emergency assistance services as follows:

a. Family-centered child welfare services as established at rule 441—172.12(234) or 441—172.22(234).

b. Shelter care as established at rule 441—202.2(234).

c. Protective child care as established at 441—subparagraph 170.2(2)*"b"*(3).

d. Tracking, monitoring, and outreach as established at rule 441—151.33(232).

133.3(5) *Receipt of assistance.* An application for IV-A emergency assistance was not previously approved within 12 months of the current application for IV-A emergency assistance.

133.3(6) *Financial eligibility.* The applicant family:

a. Is receiving FIP, SSI, food assistance benefits, or Medicaid in the month of the application, or

b. Does not have cash to provide needed emergency care or services as evidenced by the applicant family's income not exceeding 800 percent of the poverty guidelines established by the Office of Management and Budget.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—133.4(235) Method of service provision. Except for tracking, monitoring, and outreach services, services shall be provided through department workers or through purchase of service agreements with providers that are approved by the department as qualified to provide specified services and have a current contract with the department of human services to provide services.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—133.5(235) Duration of services. Services to families and children provided through the emergency assistance program as a result of a single application may be provided for either a period not to exceed 12 months or until there is no longer a need for services according to eligibility criteria for the specified services, whichever occurs first.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—133.6(235) Discontinuance of the program. The program shall be discontinued when federal funds have been exhausted.

These rules are intended to implement Iowa Code section 235.2.

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CHAPTERS 134 to 141
Reserved

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 142]
[Prior to 2/11/87, Human Services[498]]

441—142.1(238) Compact agreement. As a member of the interstate compact on placement of children, the department of human services shall cooperate on interstate aspects of placements preliminary to possible adoptions, placements in foster care where no adoption is contemplated, placements with any parent or relative, and institutional placements of adjudicated children in need of assistance needing special services or programs not available within the state. Any public or private agency instrumental in placement of a child in Iowa or from Iowa and in such public or private agency's custody shall go through the interstate compact on placement of children.

441—142.2(238) Compact administrator.

142.2(1) The compact administrator may appoint up to three deputy compact administrators to serve as active members of the association of the interstate compact on the placement of children and who shall be responsible for day-to-day operation of the interstate compact.

142.2(2) The compact administrator shall be responsible for the administration of the compact between the compact administrator's state and other contracting states.

Rules 142.1(238) and 142.2(238) are intended to implement Iowa Code section 238.33.

441—142.3(238) Article II(d). For the purposes of article II(d), a child caring agency or institution shall not include any institution caring for the mentally ill, mentally defective or epileptic; or any institution primarily educational in character; or any hospital or other medical facility.

441—142.4(238) Article III(a). For the purposes of article III(a), "sending state" shall mean "sending agency".

441—142.5(238) Article III(a) procedures.

142.5(1) All intended placements in Iowa or from Iowa coming under the purview of this compact shall be referred to the interstate compact unit, bureau of adult, children and family services, department of human services.

142.5(2) All persons involved in the placement of a child into Iowa or from Iowa into another state shall meet all the placement requirements of the receiving state prior to the actual placement.

142.5(3) Supervision of placements made by persons or agencies outside of Iowa shall be provided by a licensed Iowa agency, the department of human services, or an Iowa certified adoption investigator. Exempted from this provision are:

a. Any agency licensed as a child-placing agency in another state which has its principal place of business in a county directly adjacent to an Iowa border may practice in the Iowa counties contiguous to the out-of-state county.

b. Placement in a facility for treatment that is licensed by the department unless the department specifies that the supervision must be provided by the department for all placements in any particular facility.

441—142.6(238) Article III(c). A child may be placed in Iowa preliminary to adoption only when:

142.6(1) Rescinded by Governor's Administrative Rules Executive Order No. 3, 11/6/79.

142.6(2) There has been a preplacement investigation by an authorized person or agency in Iowa, such investigation has been made available to the Iowa interstate compact unit, the investigation has been made within the past year, and the sending state intending to place the child has been notified that the home has been approved for an adoptive placement in Iowa.

441—142.7(238) Article VIII(a). For the purpose of article VIII(a), relative shall mean stepparent, grandparent, adult brother or sister, or adult uncle or aunt, and guardian shall mean any guardian other than that appointed as preliminary to adoption.

441—142.8(238) Applicability. The requirements of this compact shall be in effect for all placements into Iowa from any state or from Iowa to any state within the United States and the District of Columbia.

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CHAPTER 143
INTERSTATE COMPACT ON JUVENILES

[Prior to 7/1/83, Social Services[770] Ch 143]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

Iowa Code section 232.171 authorizes the state of Iowa to enter into the interstate compact on juveniles and incorporates into the Iowa Code the 15 basic articles and optional amendments that govern the interstate compact for all participating parties. The department implements the interstate compact on juveniles and participates in the contractual agreement with the other 49 states, the District of Columbia, the Virgin Islands, and Guam. The contractual agreement allows the parties to cooperate on the interstate aspects of juvenile delinquency as well as the return from one state to another of nondelinquent children who have run away from home.

441—143.1(232) Compact agreement. As a member of the interstate compact on juveniles, Iowa is in a contractual agreement with the other 49 states, the District of Columbia, Puerto Rico and Guam, in which the department of human services shall cooperate on interstate aspects of juvenile delinquency, and the return from one state to another of nondelinquent children who have run away from home.

441—143.2(232) Compact administrator.

143.2(1) The compact administrator may appoint a deputy compact administrator to serve as an active member of the association of juvenile compact administrators and who shall be responsible for day-to-day operation of the interstate compact.

143.2(2) The compact administrator shall be responsible for the administration of the compact between the compact administrator's state and other contracting states.

441—143.3(232) Sending a juvenile out of Iowa under the compact.

143.3(1) Local officials requesting to transfer a juvenile to another state shall work through the office of the interstate compact administrator. All persons using the compact shall comply with the official rule and regulations promulgated by the compact administrator under authority of the compact.

143.3(2) Interstate Compact Form IA, Application for Compact Services; and Interstate Compact Form VI, Memorandum of Understanding and Waiver shall be signed by the juvenile and parents or guardian, the Iowa juvenile court judge consenting to the placement in the receiving state, and the juvenile compact deputy.

143.3(3) The Memorandum of Understanding and Waiver shall have the conditions of the probation or parole as granted by the court of jurisdiction attached.

143.3(4) Whenever a juvenile is accepted in another state for supervision, the Iowa sending agency shall send medical release and financial statements signed by the parents or guardian.

441—143.4(232) Receiving cases in Iowa under the interstate compact.

143.4(1) The department of human services shall accept supervision of out-of-state cases when a juvenile meets the requirements of the interstate compact.

143.4(2) The department of human services shall exercise the same care and treatment that is given to Iowa cases, to notify the sending state promptly of any violations or antisocial behavior that may occur.

143.4(3) No interstate juvenile shall be given permission to return to the sending state without obtaining permission from that state.

143.4(4) The receiving state shall promptly upon parole or probation violation notify the sending state. Prior to making a recommendation for revocation of parole or probation, a preliminary hearing shall be held to determine if there is probable cause for revocation of parole or probation.

143.4(5) A parolee or probationer from another state held or placed in Iowa under the provisions of article VII and who commits a felony while in Iowa shall be:

a. Returned to the sending state per mutual agreement; or

b. Processed according to the Iowa statutes and not returned to the sending state for violation.

441—143.5(232) Runaways.

143.5(1) A runaway from Iowa or to Iowa shall be returned to the state of residence only after article VI setting forth the voluntary procedures or article IV setting forth the involuntary procedures has been completed by the asylum court of jurisdiction. Denial of these procedures by the asylum court as set forth in articles IV and VI abdicates the demanding jurisdiction of any responsibility for the return under the provisions of the compact.

143.5(2) Any nondelinquent runaway from another state found in Iowa shall be held only in a nonrestrictive shelter facility until returned to the state of legal residence.

143.5(3) Any nondelinquent runaway from another state found in Iowa may be held in a nonrestrictive shelter facility beyond 48 hours on issuance of a court order to permit arrangements for return to the home state or to permit the demanding state opportunity for issuance of a requisition under article IV.

143.5(4) Any runaway from another state who is charged with a felony under Iowa Code chapter 232 may either be held in a secure setting until return to the state of legal residence or be adjudicated delinquent under Iowa Code chapter 232, placed on probation, and returned to the state of legal residence under article VII of the compact.

143.5(5) Any adjudicated delinquent who has escaped or absconded from another state and has been apprehended as a nondelinquent runaway in Iowa may be held in a secure setting awaiting return to the demanding state under article V.

143.5(6) The interstate unit shall pay for the return to Iowa of any runaway, escapee, or absconder for whom the department has, at the time the juvenile left the state, legal custody or guardianship responsibility. The interstate unit shall also pay upon request for the return of any runaway who is an Iowa resident and whose parent is unable or unwilling to pay for the juvenile's return. The responsibility for the payment for the return of a runaway, escapee, or absconder not under custody or guardianship of the department shall be that of the juvenile court having legal jurisdiction of the juvenile.

These rules are intended to implement Iowa Code section 232.171.

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CHAPTERS 144 to 149
Reserved

TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
PURCHASE OF SERVICE

[Prior to 7/1/83, Social Services[770] Ch 145]
[Previously appeared as Ch 145—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

441—150.1(234) Definitions.

"Accounting year" means a 12 consecutive month period for which accounting records are maintained. It can be either a calendar year or another designated fiscal year.

"Accrual basis accounting" means the accounting basis which shows all expenses incurred and income earned for a given time even though the expenses may not have been paid or income received in cash during the period.

"Administrative support" means technical assistance, studies, surveys, or securing volunteers to assist the department in fulfilling its administrative responsibilities.

"Agency" means an organization or organizational unit that provides social services.

1. Public agency means a general or special-purpose unit of government and organizations administered by that unit to deliver social services, for example, county boards of supervisors, community colleges, and state agencies.

2. Private nonprofit agency means a voluntary agency operated under the authority of a board of directors for purposes other than generating profit and incorporated under Iowa Code chapter 504A. An out-of-state agency must meet requirements of similar laws governing nonprofit organizations in its state.

3. Private proprietary agency means a for-profit agency operated by an owner or board for the operator's financial benefit.

"Bureau of purchased services" means a bureau of the division of fiscal management, which is responsible for administering the purchase of service system.

"Cash basis accounting" means the accounting basis which records expenses when bills are paid and income when money is received.

"Ceiling" means the maximum limit for payment for a service which has been established by an administrative rule or by the Iowa Code specifically for that service.

"Client" means an individual or family group who has applied for and been found to be eligible for social services from the Iowa department of human services.

"Common ownership" means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

"Components of service" means the elements or activities that make up a specific service.

"Contract" means formal written agreement between the Iowa department of human services and another legal entity, except for those government agencies whose services are covered under provision of Iowa Code chapter 28E.

"Contractor" means an institution, organization, facility or individual who is a legal entity and has entered into a contract with the department of human services.

"Control" means that relationship existing where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Department" means the Iowa department of human services.

"Direct cost" means those expenses which can be identified specifically and solely to a particular program.

"Donor" means a local source of funding (public or private) that enters into an Iowa donation of funds contract.

"Effective date."

1. Contract effective date for agency contracts means the first day of a month on which the contract shall become in force.

2. Effective date of rate means the date specified in a purchase of service contract on which the specified rate of payment for service provided begins.

"Field staff" means department employees outside of central office reporting to the deputy director of field operations.

"Grant" means an award of funds to develop specific programs or achieve specific outcomes.

"Indirect cost" means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

"Project manager" means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

"Provider" means an institution, organization, facility, or individual who is a legal entity and has entered into a contract with the department to provide social services to clients of the department.

"Purchase of service system" means the system within the department for contracting and payment for services, including contracts for funding and contracts for technical assistance.

"Related to provider" means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

"Relatives" include the following persons: husband and wife, natural parent and child, sibling, adopted child and adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent and grandchild.

"Social services" means a set of actions purposefully directed toward human needs which are socially identified as requiring assistance from others for their resolution.

"Unit of service" means a specified quantity of service or a specific outcome as a result of the service provided.

441—150.2(234) Categories of contracts.

150.2(1) *Iowa purchase of social services contract.* An Iowa purchase of social services contract is a legal contract between the department and a provider for a specified service or services to clients referred by the department. This contract establishes the components of service to be provided, the rate per unit of service, a maximum number of units to be available, and other negotiated conditions. The department has three types of contracts for purchasing social services.

a. An agency contract is a contract written with an agency. Iowa Purchase of Social Services Agency Contract, Form 470-0628, shall be completed prior to services being purchased from the agency.

b. A child care certificate is an agreement written with a licensed child care center, a family day care home, a group day care home, an in-home care provider, or a relative care provider. Policies governing child care certificates may be found in 441—Chapter 170.

c. An individual in-home health-related provider agreement is an agreement written with an individual provider of in-home health services. Policies governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

150.2(2) *Iowa purchase of administrative support contract.* An Iowa purchase of administrative support contract is between the department and a contractor for the provision of administrative support. This contract establishes the support services to be provided, the rate and the method of payment, and other negotiated conditions. A contractor or the division of a contractor who is a multiservice organization holding an administrative support contract may not provide direct client services during the period of the contract.

a. A volunteer contract is the administrative support contract between an individual or agency and the department to secure volunteers to assist the department in service delivery.

b. A general use administrative support contract is between the department and a contractor for the provision of administrative support.

150.2(3) *County board of supervisors' participation contract.* Rescinded IAB 7/8/92, effective 7/1/92.

150.2(4) *Iowa donation of funds contract.* The department may accept donated funds.

a. Upon mutual agreement regarding the scope and use of the funds to be donated, the department may negotiate and shall execute a contract between the department and the donor in accordance with department of administrative services rules in 11—Chapters 106 and 107. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds.

b. Except for restrictions permitted by the contract, all funds shall be donated on an unrestricted basis for use as if they were appropriated funds and shall be under the administrative control of the department. The donor may specify the geographic area to be served and the specific service to be provided.

c. No funds donated and transmitted to the department will be returned to the donor unless specified in the contract.

441—150.3(234) Iowa purchase of social services agency contract.

150.3(1) *Initiation of contract proposal.* When the department issues a request for proposal to select providers, the process and conditions for approving contract proposals shall be as specified in the request, and the department shall not be required to contract with a provider that is not selected. Otherwise, the following procedures for initiation of contract proposals shall apply.

a. *Right to request a contract.* All potential provider agencies have a right to request a contract.

b. *Initial contact.* The initial contact should be between the potential provider and the service area manager for the service area in which the provider's headquarters is located. In the case of out-of-state providers, this contact can be with the service area manager for either the closest service area or the service area initiating the contact. At the beginning of the process of developing a contract, the bureau of purchased services shall give the provider:

(1) Information about the contracting process; and

(2) Instructions on how to access the Purchase of Service Provider Handbook electronically.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This information shall include documentation that the conditions of participation are met. Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, shall be completed at the same time as Form 470-0628, Iowa Purchase of Social Services Agency Contract, or Form 470-0630, Amendment or Renewal of the Iowa Purchase of Social Services Agency Contract, is prepared.

d. *Contract proposal approval or rejection.* Before a contract can be effective, it shall be signed by the following persons within the time frames provided:

(1) Authorized representative of the provider agency.

(2) Service area manager, within one week from receipt.

(3) Rescinded IAB 5/11/05, effective 5/1/05.

(4) Chief of the bureau of purchased services, within 30 days from receipt.

The provider shall be given a notice and explanation in writing of delays in the process or of rejection of the proposal. Payment cannot be made until the contract is signed by the provider's authorized representative and the chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected:

(1) The service is not needed by department clients.

(2) The service is not in the social services block grant plan for the counties to be served by the program.

(3) No funds are available for the service being proposed.

(4) The proposed contract does not meet applicable rules, regulations, or guidelines, including service definition.

f. *Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the chief of the bureau of purchased services.

150.3(2) *Contract administration.*

a. *Contract management.* During the contract period the assigned project manager shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance, if needed. Report of On-Site Visit, Form 470-0670, may be used to monitor performance under the contract.

b. *Contract amendment.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of services shall include reestablishment of applicable rates. Amendment or Renewal of Iowa Purchase of Social Services Agency Contract, Form 470-0630, shall be used to amend or renew the contract.

c. *Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days before the expiration date.

(1) Each contract shall be evaluated. The department shall take the results of the evaluation into consideration in making the decision on renewal. This evaluation may involve use of the Monitoring and Evaluation Review Guide, Form 470-2571, or other evaluation tools specified in the contract.

(2) Desk Audit for Civil Rights Contract Compliance, Form 470-2215, shall be completed by the provider.

d. *Contract termination.* Causes for termination during the period of the contract are:

(1) Mutual agreement of the parties involved.

(2) Demonstration that sufficient funds are unavailable to continue the services involved.

(3) Failure to make required reporting.

(4) Failure to make financial and statistical records available for review.

(5) Failure to abide by the provisions of the contract.

150.3(3) *Conditions of participation.* The provider shall meet the following standards:

a. *Licensure, approval, or accreditation.* The provider shall have any license, approval, and accreditation required by law, regulation or administrative rules, or standards of operation required by the state or the federal government before the contract can be effective. Out-of-state providers shall meet Iowa licensing standards related to treatment, professional staff to client ratio, and staff qualifications.

b. *Signed contract.* A contract can be effective only when signed by all parties required in 150.3(1)*"d."*

c. *Civil rights laws.* The providers shall be in compliance with all federal, state and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

d. *Title VI compliance.* The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

e. *Section 504 compliance.* The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, Plan Review Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

f. *Affirmative action.* The provider shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

g. *Abuse reporting.* The provider shall have a written policy and procedure approved by the service area manager or designee for reporting abuse or denial of critical care of children or dependent adults.

h. *Confidentiality.* The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure approved by the service area manager or designee for maintaining individual client confidentiality including client record destruction.

i. *Client appeals and grievances.* Clients receiving service through a purchase of service contract have the right to appeal adverse decisions made by the department or the provider. The provider shall have a written policy and procedure approved by the service area manager or designee for handling client appeals and grievances and shall provide information to clients about their rights to appeal.

j. *Client reports.* The provider shall maintain the following client records:

(1) Provider service plan or individual program plan. Providers shall develop a written service plan or individual program plan for each client within 30 days of service initiation. The plan shall include a concise description of the situation or area which will be the focus of the service; statement of the goals to be achieved through the delivery of services; time limited and measurable objectives which will lead to the attainment of the goal to be achieved; specific service components, frequency, and the assignment of responsibility for the provision of the components; and the month and year when it is estimated the client will be able to achieve the current goals and objectives. The provider service plan shall be updated upon receipt of a new departmental case plan, but at least once every six months.

(2) Quarterly progress reports. Quarterly progress reports shall be sent to the department service worker responsible for the client. The first report shall be submitted to the department three months after service is initiated. Reports shall be submitted quarterly thereafter, unless provided for otherwise in rules for a specific service.

The progress report shall include a description of the specific service components provided, their frequency, and who provided them; the client's progress with respect to the goals and service objectives; and any recommended changes in the service plan or individual program plan. For all placement cases the report shall include interpretation of the client's reaction to placement, a summary of medical or dental services that were provided, a summary of educational or vocational progress and participation, and a summary of the involvement of the family with the client and the services.

Reports for the supervised apartment living service shall also include supporting documentation for service provision. The documentation shall list dates of client and collateral contacts, type of contact, persons contacted, and a brief explanation of the focus of each contact. Each unit of service for which payment is sought should be the subject of a written progress note.

(3) Termination of service summary. A termination of service summary shall be sent to the department service worker responsible for the client within two weeks of service termination. The summary shall include the rationale for service termination and the impact of the service components on the client in relationship to the established goals and objectives.

k. *Financial and statistical records.* Each provider of service must maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, and state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

l. *Reports on financial and statistical records.* Reports on financial and statistical records shall be submitted as required. Failure to do so within the required time limits is grounds for termination of the contract.

m. Maintenance of client records. Records for clients served through a purchase of service contract must be retained by the provider for a period of three years after service to the client terminates.

n. Provider charges. A provider shall not charge department clients more than it receives for the same services provided to nondepartmental clients.

o. Special-purpose organizations. A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or nonclient-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, a special-purpose organization is considered to be related to a provider if:

(1) The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies; or

(2) The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with intent of benefiting the provider.

The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider; or

The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

p. Certification by department of transportation.

(1) If the provider furnishes public transit service as defined in 761—910.1(324A), the provider shall annually submit to the project manager information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

1. Form 020107, Certification Application for Coordination of Public Transit Services, which the project manager shall submit to the department of transportation; and

2. A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

(2) If a provider believes it does not furnish public transit service as defined in 761—910.1(324A) and therefore is exempt from the requirements in subparagraph (1), the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

(3) If a provider that has furnished public transit service as defined in 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in subparagraph (1).

(4) If an exempt provider begins to furnish public transit service as defined in 761—910.1(324A), the provider shall inform the project manager within 30 days of the change and shall adhere to the procedures in subparagraph (1).

(5) Failure of the provider to cooperate in obtaining or providing the required documentation for compliance or exemption is grounds for denial or termination of the contract.

q. Services provided. Services provided, as described in Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, and attachments, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular service or the contract may be terminated.

r. Bonding, indemnity and insurance clauses.

(1) Rescinded IAB 2/3/93, effective 4/1/93.

(2) Indemnity. The provider agrees that it will at all times during the existence of this contract indemnify and hold harmless the department and county against any and all liability, loss, damages, costs or expenses which the provider may hereafter sustain, incur or be required to pay:

1. By reason of any client's suffering personal injury, death or property loss or damages either while participating in or receiving from the provider the care and services to be furnished by the provider under this contract, or while on premises owned, leased, or operated by the provider, or while being

transported in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the provider or any officer, agency, or employee thereof.

2. By reason of any client's causing injury to or damage to another person or property during any time when the provider or any officer, agency or employee thereof has undertaken or is furnishing the care and service called for under this contract.

(3) Insurance. The provider agrees that in order to protect itself as well as the department and county under the indemnity agreement above, it will at all times during the term of the contract have and keep in force a liability insurance policy, verification of which shall accompany Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet. The provider agrees that all employees, volunteers, or any other person, other than employees of the department acting within the scope of their employment in the department, authorized to transport clients in privately owned vehicles, have liability insurance in force.

s. Renegotiation clause. In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

t. Performance measures. The department may require performance measures.

150.3(4) *Establishment of rates.* The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, is the basis for establishing the rates to be paid to all providers under an Iowa Purchase of Social Services Agency Contract, Form 470-0628, except as provided below.

a. Injectable contraceptive unit. Rescinded IAB 8/1/07, effective 9/5/07.

b. Out-of-state providers.

(1) Rescinded IAB 9/1/93, effective 11/1/93.

(2) Out-of-state providers of other services shall have rates established using the applicable portions of the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664.

c. Family-centered flexible supportive services. Rescinded IAB 5/6/09, effective 7/1/09.

150.3(5) *Financial and statistical report.* The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, shall be completed by those providers as required in 150.3(4). The reports shall be based on the following rules.

a. Accounting procedures. 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 who are multiple program agencies shall submit a cost allocation schedule prepared in accordance with recognized methods and procedures.

(1) Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor supervises more than one program.

(2) Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program. They may also be charged as direct program expenses when a method of distribution acceptable to the department is maintained on a consistent basis.

(3) Occupancy expenses shall be allocated to programs on a space utilization formula. The space utilization formula may be used for salaries and fringes of building maintenance and janitorial type personnel.

(4) All expenses which relate jointly to two or more programs shall be allocated to program service costs by utilizing a cost allocation method which fairly distributes costs to the related programs. Any expenses which relate directly to a particular program shall be reflected as such. All maintenance costs shall be charged directly or allocated proportionately to the related programs affected.

(5) Indirect program service costs shall be distributed over all applicable services.

(6) Expenses such as supplies, conferences, and similar expenses that cannot be directly related to a program shall be charged to indirect program service costs.

(7) A multiservice agency shall establish a method acceptable to the department of distributing indirect program service costs.

(8) Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

If a shelter care provider's actual and allowable costs for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs, or the statewide average of actual and allowable costs in May of the preceding year for juvenile shelter care homes, whichever is less.

(9) When an agency has a certified public accounting firm perform an audit of its financial statements, the resulting audit report shall follow one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants. These formats are specified in the industry audit guide series, "Audits of Voluntary Health and Welfare Organizations," prepared by the Committee on Voluntary Health and Welfare Organizations, American Institute of Certified Public Accountants, New York, 1974. A copy of the certified audit report shall be submitted to the department within 60 days of receipt.

(10) All expenses reported on Form 470-0664 shall be supported by an agency's general ledger and documentation on file in the agency's office.

b. Failure to maintain records. Failure to maintain records adequate to support the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, may result in termination of the contract. These records include, but are not limited to:

(1) Reviewable, legible census reports.
(2) Payroll information.
(3) Capital asset schedules.
(4) All canceled checks, deposit slips, invoices (paid and unpaid).
(5) Audit reports (if any).
(6) Board of directors' minutes.

c. Submission of reports. The financial and statistical report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. At least one week must be allowed prior to this deadline for the project manager to review the report and transmit it to the bureau of purchased services in central office. Failure to submit the report in time without written approval from the chief of the bureau of purchased services may reduce payment to 75 percent of the current rate. Failure to submit the report within six months of the end of the fiscal year shall be cause for terminating the contract.

d. Rate modification. Modification of rates shall be made when required by changes in licensing requirements, changes in the law, or amendments to the contract. Requests for modification of a rate may be made when changes are because of program expansion or modification and have the approval of the service area where services are provided. Even if there is a modification of the rate, the modified rate is still subject to any maximum established in any law or rule.

e. Payment of new rate. New rates shall be effective for services provided beginning the first day of the second calendar month after receipt by the bureau of purchased services of a report sufficient to establish rates or, by mutual agreement, new rates shall be effective the first day of the month following completion of the fiscal review. Failure to submit a report sufficient to establish a rate will result in the effective date's being delayed. At least one week must be allowed prior to the deadline in paragraph *"c"* above for the project manager to review the report and transmit it to central office.

f. Exceptions to costs. Exceptions to costs identified by the bureau of purchased services or its fiscal consultant will be communicated to the provider in writing.

g. *Accrual basis.* Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

h. *Census data.* Documentation of units of service provided which identifies the individual client shall be available on a daily basis and summarized on a monthly report. The documentation and reports shall be retained by the provider for review at the time the expenditure report is prepared and reviewed by the department's fiscal consultant.

i. *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 noncompliance with reporting instructions.

j. *Revenues.* When the Financial and Statistical Report is completed, revenues shall be reported as recorded in the general books and records adjusted for accruals. Expense recoveries shall be reflected as revenues.

k. *Capital asset use allowance (depreciation) schedule.* The Capital Asset Use Allowance Schedule shall be prepared using the guidelines for provider reimbursement in the Medicare and Medicaid Guide, December 1981.

l. *The following expenses shall not be allowed:*

(1) Fees paid directors and nonworking officers' salaries.

(2) Bad debts.

(3) Entertainment expenses.

(4) Memberships in recreational clubs, paid for by an agency (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the employees of the agency.

(5) Legal assistance on behalf of clients.

(6) Costs eligible for reimbursement through the medical assistance program.

(7) Food and lodging expenses for personnel incurred in the city or immediate area surrounding the personnel's residence or office of employment, except when the specific expense is required by the agency and documentation is maintained for audit purposes. Food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, guardians, or consultants are allowable expenses when documentation is available for audit purposes.

(8) Business conferences and conventions. Meeting costs of an agency which are not required in licensure.

(9) Awards and grants to recognize board members and community citizens for achievement. Awards and grants to clients as part of treatment program are reimbursable.

(10) Survey costs when required certification is not attained.

(11) Federal and state income taxes.

m. *Limited service—without a ceiling.* The following expenses are limited for service without a ceiling established by administrative rule or law for that service. This includes services with maximum rates, with the exception of shelter care.

(1) Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of locating qualified individuals for staff positions are allowed for reimbursement purposes.

(2) and (3) Rescinded IAB 5/18/88, effective May 1, 1988.

(4) Costs for participation in educational conferences are limited to 3 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report.

(5) Costs of reference publications and subscriptions for program-related materials are limited to $500 per year.

(6) Memberships in professional service organizations are allowed to the extent they do not exceed one-half of 1 percent of the total salary costs less excluded salary costs.

(7) In-state travel costs for mileage and per diem expenses are allowable to the extent they do not exceed the maximum mileage and per diem rates for state employees for travel in the state.

(8) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (7) above.

(9) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is $40,000 annually.

(10) Annual meeting costs of an agency which are required in licensure are allowed to the extent required by licensure.

n. Limited service—with a ceiling. The following expenses are limited for services with a ceiling established by administrative rule or law for that service. This includes shelter care.

(1) The maximum reimbursable compensation for the agency administrator or executive director charged to purchase of service annually is $40,000.

(2) Annual meeting costs of an agency which are required for licensure are allowed to the extent required by licensure.

o. Establishment of ceiling and reimbursement rate.

(1) The maximum allowable rate ceiling applicable to each service is found in the rules for that particular service.

(2) When a ceiling exists, the reimbursement rate shall be established by determining on a per unit basis the allowable cost plus the current cost adjustment subject to the maximum allowable cost ceiling.

p. Rate limits. Interruptions in service programs will not affect the rate. If an agency assumes the delivery of service from another agency, the rate shall remain the same as for the former agency.

(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the financial and statistical report submitted to the department. For the fiscal year beginning July 1, 2013, the maximum reimbursement rate shall be $96.98 per day, based on a 365-day year. If the department reimburses the provider at less than the maximum rate, the department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost plus the inflation factor or to the maximum reimbursement rate, whichever is less.

(2) The initial reimbursement rate for any new service shall be based upon actual and allowable costs. A new service does not include a new building or location or other changes in method of service delivery for a service currently provided under the contract.

1. For shelter care, if the provider is currently offering shelter care under social services contract, the only time the provider shall be considered to be offering a new service is if the provider adds a service other than shelter care.

2. For supervised apartment living, the only time a provider shall be considered to be offering a new service is when the agency adds a cluster site or a scattered site for the first time. If, for example, the agency has a supervised apartment living cluster site, the addition of a new site does not constitute a new service.

3. If the department defines, in administrative rule, a new service as a social service that may be purchased, this shall constitute a new service for purposes of establishment of a rate. Once the rate for the new service is established for a provider, the rate will be subject to any limitations established by administrative rule or law.

(3) If a social service provider loses a source of income used to determine the reimbursement rate for the provider, the provider's reimbursement rate may be adjusted to reflect the loss of income, provided that the lost income was used to support actual and allowable costs of a service purchased under a purchase of service contract.

q. Related party costs. Direct and indirect costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider are includable in the allowable cost of the provider at the cost to the related organization. All costs allowable at the provider level are also allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

(1) Allowable costs shall be all actual direct and indirect costs applying to any service or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

(2) When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a

schedule displaying amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 150.3(5)*"a"*(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in 150.3(3)*"k."*

(3) Tests for relatedness shall be those specified in rule 441—150.1(234) and 150.3(3)*"o."* The department or the purchase of service fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and list of board members.

r. *Day care increase.* Rescinded IAB 7/7/93, effective 7/1/93.

s. *Interest on unpaid invoices.* Any invoice that remains unpaid after 60 days following the receipt of a valid claim is subject to the payment of interest. The rate of interest is 1 percent per month beyond the 60-day period, on a simple interest basis. A separate claim for the interest is to be generated by the agency. If the original claim was paid with both federal and state funds, only that portion of the original claim paid with state funds will be subject to interest charges.

t. *Interest as an allowable cost.* 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 required to operate a program, 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.

u. *Rate formula.* Paragraph 150.3(5)*"p"* notwithstanding, when rates are determined based on cost of providing the service involved, they will be calculated according to the following mathematical formula:

$$\frac{\text{Net allowable expenditures}}{\text{Effective utilization level}} \times \text{Reimbursement factor} = \text{Base Rate}$$

(1) Net allowable expenditures are those expenditures attributable to service to clients which are allowable as set forth in subrule 150.3(5), paragraphs *"a"* to *"t."*

(2) Effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

(3) Inflation factor is the percentage which will be applied to develop payment rates consistent with current policy and funding of the department. The inflation factor is intended to overcome the time lag between the time period for which costs were reported and the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(4) Base rate is the rate which is developed independent of any limits which are in effect. Actual rates paid are subject to applicable limits or maximums.

v. Rescinded IAB 5/13/92, effective 4/16/92.

150.3(6) *Client eligibility and referral.*

a. Program eligibility. To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the department.

(1) The department shall not make payment for services provided before the client's application, eligibility determination, and referral. See *"b"* below for an exception to this requirement.

(2) Except as provided in paragraph *"c,"* the department shall use the following forms to authorize services:

1. Form 470-0622, Referral of Client for Purchase of Social Services.
2. Form 470-0719, Placement Agreement: Child Placing or Child Caring Agency (Provider).

b. When a court orders foster care and the department has no responsibility for supervision or placement of the client, the department will pay the rate established by these rules for maintenance and service provided by the facility.

c. Family-centered services. For family-centered services, the provisions in rule 441—172.3(234) relating to approval, authorization, and referral shall apply.

150.3(7) *Client fees.* The provider shall agree not to require any fee for service from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy. Rules governing client fees are found in 441—130.4(234).

The provider shall collect fees due from clients. The provider shall maintain records of fees collected, and these records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment. When the second notice of nonpayment is sent, the provider shall send a copy of the notice to the department worker.

150.3(8) *Billing procedures.* At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred, each service, and each funding source involved in payment. Complete invoices shall be sent to the departmental county office responsible for the client for approval and forwarding for payment.

More frequent billings may be permitted on an exception basis with the written approval of the service area and the chief of the bureau of purchased services.

a. Time limit for submitting vouchers, invoices, or claims. The time limit for submission of original vouchers, invoices, or claims shall be three months from the date of service.

b. Resubmittals of rejected claims. Valid claims which were originally submitted within the time limit specified in paragraph *"a"* but were rejected because of an error shall be resubmitted without regard to time frames.

150.3(9) *Reviews of departmental actions.* A provider who is adversely affected by a departmental decision may request a review. A review request may cause the action to be stopped pending the outcome of the review, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. The provider shall send a written request for review to the project manager responsible for the contract within ten days of receipt of the decision in question. This request shall document the specific area in question and the remedy desired. The project manager shall provide a written response within ten days.

b. When dissatisfied with the response, the provider shall submit to the service area manager within ten days the original request, the response received, and any additional information desired. The service area manager shall study the concerns and the action taken, and render a decision in writing within 14 days. A meeting with the provider may be held to clarify the situation.

c. If still dissatisfied, the provider may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs *"a"* and *"b"* above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting may be held with the provider, project manager, and service area manager or designee.

d. The provider may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.3(10) *Review of financial and statistical reports.* Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.3(5). Representatives shall provide proper identification and shall use generally

accepted auditing principles. The reviews may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

150.3(11) Rescinded, effective 3/1/87.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8447B**, IAB 1/13/10, effective 1/1/10; **ARC 8651B**, IAB 4/7/10, effective 5/12/10; **ARC 8902B**, IAB 6/30/10, effective 7/1/10; **ARC 0860C**, IAB 7/24/13, effective 7/1/13; **ARC 1060C**, IAB 10/2/13, effective 11/6/13]

441—150.4(234) Iowa purchase of social services contract—individual providers.

150.4(1) *Individual child day care provider agreement.* Rules governing individual child day care provider agreements may be found in 441—Chapter 170.

150.4(2) *Individual in-home health-related provider agreement.* Rules governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

441—150.5(234) Iowa purchase of administrative support.

150.5(1) *Initiation of contract proposal.*

a. *Right to request a contract.* All potential contractors have a right to request a contract.

b. *Initial contact.*

(1) Volunteer contract. The initial contact for a volunteer contract may be between the potential contractor and the service area manager of the service area in which the individual or the contractor agency's headquarters is located or the contract may be between the potential contractor and the director of the state volunteer program in the central office of the department. If so, the director will communicate with the service area.

(2) General use administrative support contract. The initial contact for a general use administrative support contract may be between the potential contractor and the service area manager of the service area in which the individual or contractor organization's headquarters is located or the contract may be between the potential contractor and the chief of the bureau of purchased services, who will communicate with the service area.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This includes documentation that the conditions of participation required below are met.

d. *Contract proposal approval or rejection.* Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Volunteer contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Director of the state volunteer program within 30 days from receipt.

(2) General use administrative support contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Chief of the bureau of purchased services within two weeks from receipt.

Administrator of the division of fiscal management within two weeks from receipt.

The contractor shall be notified of delays in the process or of rejection of the proposal. This notification along with an explanation shall be in writing. The applicant has a right to have the decision reviewed by the director of the state volunteer program, or chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected.

(1) The proposed activity is not needed by the department.

(2) No funds are available for the activity being proposed.

(3) The proposed contract does not meet applicable rules, regulations, or guidelines.

f. *Contract effective date.* If the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the director of the state volunteer program, or the chief of the bureau of purchased services.

150.5(2) *Contract administration.*

a. *Contract management.* During the contract period, the assigned project manager shall be the liaison between the department and the contractor. The project manager shall be contacted on all interpretations and problems related to the contract and shall follow issues through to their resolution. The project manager shall also monitor performance under the contract and will provide or arrange for technical assistance to improve the contractor's performance, if needed.

b. *Contract amendments.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of providing the volunteer services must include reestablishment of amounts to be paid.

c. *Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days prior to the expiration date. Each contract shall be evaluated. The results of the evaluation shall be taken into consideration in the decision on renewal. This evaluation may involve use of evaluation tools specified in the contract.

d. *Contract termination.* Causes for termination during the period of the contract are:

(1) Mutual agreement of the parties involved.

(2) Demonstration that sufficient funds are unavailable to continue the service(s) involved.

(3) Failure to make reports required by the contract.

(4) Failure to make financial, statistical, and program records available.

(5) Failure to abide by the provisions of the contract.

150.5(3) *Conditions of participation.* The contractor shall meet the following standards:

a. *Licensure, approval, or accreditation.* The contractor shall have any license, approval, and third-party accreditation required by law, regulation, or administrative rules, or shall meet standards of operation required by state or federal regulation. This requirement must be met before the contract can be effective.

b. *Signed contract.* A contract can be effective only when signed by all parties required in 150.5(1)*"d."*

c. *Civil rights laws.* The contractors shall be in compliance with all federal, state, and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance.

d. *Title VI compliance.* The contractors shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance.

e. *Section 504 compliance.* The contractors shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance.

f. *Affirmative action.* The contractors shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance.

g. *Abuse reporting.* The contractor shall have an approved policy and procedure for reporting abuse or denial of critical care of children or dependent adults.

h. *Confidentiality.* The contractor shall comply with all applicable federal and state laws and regulations on confidentiality.

i. *Financial and statistical records.* Each contractor of service shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, or state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

j. Certification by department of transportation. Each contractor who supplies transportation services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of "Certificate of Insurance" (an ACORD form or similar or self-insurance documentation) to the applicable project manager annually showing information regarding compliance with, or exemption from, public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to provide the required documentation for compliance or exemption is grounds for denial or termination of the contract.

150.5(4) *Establishing amounts to be paid.* The amounts to be paid under purchase of administrative support contracts are actual approved expenses as negotiated in the contract. Approved items of cost are based on submission of a proposed budget listing those items necessary for provision of the volunteer coordination or technical assistance to be delivered. At the termination of the contract a statement of actual expenses incurred shall be submitted by the contractor.

150.5(5) *Billing procedures.* At the end of each month, or as otherwise provided in the contract, the contractor shall prepare a claim on Form GAX, General Accounting Expenditure, for expenses for which reimbursement is permitted in the contract. The claim shall be sent to the office of the department that administers the contract for approval and forwarding for payment.

a. Time limit for submitting claims. The time limit for submission of original claims shall be within 90 days of the provision of service.

b. Resubmittals of rejected claims. Valid claims which were originally submitted within this time limit but were rejected because of an error must be resubmitted, but without regard to time frames.

150.5(6) *Reviews of department actions.* A contractor who is adversely affected by a department decision may request a review. A review request may cause the action to be stopped pending the outcome of the review process, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. Within ten days of receipt of the decision in question the contractor shall send a written request for review to the project manager responsible for the contract. This request shall document the specific area in question and the remedy desired. A written response from the project manager shall be provided within ten days.

b. When dissatisfied with the response, the contractor shall submit the original request, the response received, and any additional information desired to the service area manager within ten days. The service area manager shall study the concerns, the action taken and render a decision in writing within 14 days. A meeting with the contractor may be held to clarify the situation.

c. If still dissatisfied, the contractor may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs *"a"* and *"b"* above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting with the contractor, project manager, and service area manager or designee may be held.

d. The contractor may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.5(7) *Reviews.* Authorized representatives of the department or state or federal audit personnel have the right to review the general financial records of a contractor. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.5(4). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may be on the basis of an on-site visit to the contractor, the contractor's central accounting office, the offices of the contractor's agents, a combination of these, or, by mutual decision, to other locations.

This rule is intended to implement Iowa Code sections 234.6 and 324A.5, subsection 3, paragraph *"c."*

441—150.6(234) County board of supervisors participation contract. Rescinded IAB 7/8/92, effective 7/1/92.

441—150.7(234) Iowa donation of funds contract. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.8(234) Provider advisory committee. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.9(234) Public access to contracts. Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 2001 Iowa Acts, House File 732, section 31, subsection 6, and Senate File 537, section 1, subsection 1, paragraph *"d."*

441—150.10 to **150.20** Reserved.

DIVISION II
PURCHASE OF SOCIAL SERVICES CONTRACTING ON BEHALF OF COUNTIES FOR LOCAL PURCHASE SERVICES FOR ADULTS WITH MENTAL ILLNESS, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES
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CHAPTER 151
JUVENILE COURT SERVICES DIRECTED PROGRAMS

[Prior to 7/1/83, Social Services[770] Ch 141]
[770—Ch 141 renumbered as 498—Ch 209, IAB 2/29/84]
[Agency number changed from [498] to [441] IAB 2/11/87]
[Prior to 7/26/89, 441—Ch 209]

PREAMBLE

These rules prescribe services for children eligible for reimbursement from funds appropriated specifically for juvenile court services directed programs. The state court administrator and chief juvenile court officers have primary responsibility for the administration of court-ordered services and graduated sanction services for children. The graduated sanction services are also known as "early intervention and follow-up services" or "community-based delinquency programs."

The juvenile court services directed programs addressed in this chapter include court-ordered services and four graduated sanction programs: life skills; school-based supervision; supervised community treatment; and tracking, monitoring, and outreach. The rules establish the criteria for the allocation of funds and the procedures for administration, application, eligibility, appeals, service delivery, and billing and payment.

DIVISION I
GENERAL PROVISIONS

PREAMBLE

These rules, pursuant to the authority granted in the Iowa Code and annual appropriations Acts, prescribe the relationship between the state court administrator (the judicial branch), the chief juvenile court officer from each judicial district, and the department of human services (the executive branch) in the administration of the funds for the juvenile court services directed programs. These rules also prescribe the joint responsibilities of the chief juvenile court officers and the department's service area managers for the planning and implementation of an annual child welfare and juvenile justice plan for each department service area.

441—151.1(232) Definitions.

"At risk" or *"high risk"* means that a child has been referred to juvenile court services for a delinquency violation or has exhibited behaviors likely to result in a juvenile delinquency referral.

"Case file" means a file that includes referral information, information generated during assessment, documentation of court proceedings, other eligibility determinations, case plans, and case reports, including quarterly progress reports. Case files of providers also include records of provider-child contact that document provision of services.

"Case record" means a minimal record that identifies the child and the service provided and documents the child's eligibility. A case record is maintained when a case file is not required.

"Certification of the court" means that the chief juvenile court officer has determined that (1) the court-ordered services fall within the defined services pursuant to Iowa Code section 232.141, subsections (4) and (5), and (2) there are sufficient funds in the district's fiscal year fund allocation to pay for all court-ordered services.

"Child" means a person under 18 years of age. "Child" also includes a person up to 19½ years of age when (1) the person is adjudicated delinquent and the dispositional order is entered while the person is 17 years of age (in which case, the order terminates 18 months after the date of disposition), or (2) the person, as an adult, has been transferred to the jurisdiction of the juvenile court and is adjudicated

as having committed a delinquent act before becoming an adult (in which case, the dispositional order automatically terminates 18 months after the last date upon which jurisdiction could attach).

"Child welfare and juvenile justice plan" means the annual plan for using decategorized funds within each department service area.

"Court-ordered services" means the defined or specific care and treatment that are ordered by the court for an eligible child and for which no other payment source is available to cover the cost.

"Department" means the department of human services.

"Eligible child" means a child who has been adjudicated delinquent, is at risk, or has been certified by the chief juvenile court officer as eligible for court-ordered services.

"Graduated sanction services" means life skills; school-based supervision; supervised community treatment; and tracking, monitoring, and outreach. Graduated sanction services are provided in community-based settings to children who are adjudicated delinquent or who are at risk of adjudication. Services are directed to help children transition into productive adulthood and to prevent or reduce criminal charges, out-of-home placement, and recidivism. Graduated sanction services are also known as "early intervention and follow-up services" or "community-based delinquency programs."

"Juvenile court officer" means a person appointed as a juvenile court officer or a chief juvenile court officer under Iowa Code chapter 602.

"Provider" means a public agency, including a school district or government unit, or a private agency, organization or eligible individual authorized to do business in the state. The provider is also known as the claimant.

441—151.2(232) Administration of funds for court-ordered services and graduated sanction services. Pursuant to the authority granted in Iowa Code chapters 232, 602, 7E, and 8 and the annual appropriations Acts, the executive branch, represented by the department, and the judicial branch, represented by the state court administrator and the chief juvenile court officers, are each charged with specific responsibilities for funding, administering, and providing graduated sanction services and court-ordered services.

151.2(1) *Allocations for court-ordered services.* Court-ordered services are funded by an appropriation made to the department for allocation by the state court administrator.

a. The state court administrator shall allocate the funds, minus the administrative set-aside specified in the appropriations bill, to the eight judicial districts for the payment of the expenses of court-ordered services provided to juveniles that are a charge upon the state pursuant to Iowa Code section 232.141, subsection (4), and also as allowed by subsection 5.

b. The state court administrator may use not more than the administrative set-aside, specified in the appropriations bill, for the costs of administering the court-ordered services program, including the costs of travel associated with court-ordered placements, that are a charge to the state pursuant to Iowa Code section 232.141, subsection (4).

c. The state court administrator shall allocate the funds, minus the administrative set-aside, among the judicial districts on or before the date directed by the legislature.

(1) The state court administrator shall base the allocation on each district's respective portion of the statewide population of children as reported in current census data.

(2) The source of the census data shall be determined and agreed upon by the state court administrator and the chief juvenile court officers.

151.2(2) *Allocations for graduated sanction services.* Graduated sanction services are funded by an appropriation to the department. The department allocates the funds to the state court administrator and to the chief juvenile court officers for administration. The funds are allocated and administered as follows:

a. The department shall allocate a set-aside amount up to, but not to exceed, 10 percent of the total allocation for graduated sanction services for the state court administrator to pay the administrative costs of the graduated sanction services, including the costs of a court accountant auditor position established in each judicial district.

b. The state court administrator shall:

(1) Establish and implement a written job classification and pay schedule for the court accountant auditor positions; and

(2) Administer the set-aside for the eight judicial districts.

c. The department shall allocate the funds for each of the four graduated sanction programs, minus the administrative set-aside, among the eight judicial districts based on each district's respective portion of the statewide population of children as reported in current census data. The source of the census data shall be determined and agreed upon by the department and the chief juvenile court officers.

151.2(3) *Transfer of funds to a decategorization governance board for administration.* Funds allocated to a district for court-ordered services or graduated sanction services, less the administrative set-asides, may be transferred to a decategorization governance board for administration.

a. To initiate a transfer of funds to a decategorization governance board:

(1) The chief juvenile court officer shall submit to the chair of the decategorization governance board a written notice of intent to transfer the funds to the board. The chief shall include in the notice a statement identifying any special conditions or limitations to which the funds would be subject. If no statement identifying any special conditions or limitations to which the funds would be subject is included, then no special conditions or limitations apply.

(2) The chair of the decategorization governance board shall provide the chief juvenile court officer with a written statement of acceptance of the funds; otherwise the chief juvenile court officer shall not transfer the funds. When the chief juvenile court officer has identified special conditions or limitations that apply to the funds, the decategorization governance board chair's signature on the written statement of acceptance of the funds indicates agreement with the special conditions or limitations.

(3) The chief juvenile court officer shall submit the written request to transfer the funds and the written statement of acceptance to the department.

b. The department must receive a signed agreement transferring the funds before the department signs any contract using the funds.

c. The decategorization governance board may authorize the chief juvenile court officer to act on behalf of the decategorization governance board in the administration of the funds, but is not required to do so. An authorization from the decategorization governance board granting authority to the chief juvenile court officer to act on behalf of the decategorization governance board in the administration of the funds must be in writing and must be received by the department before the department representative signs any contract using the funds. The request and authorization to administer the funds may be included in the request and agreement to transfer the funds.

d. Funds transferred to a decategorization governance board for administration are subject to the same audit requirements as specified in 151.6(1).

151.2(4) *Availability of funds.* The chief juvenile court officers, the state court administrator, and the department shall monitor the availability of the court-ordered services funds to ensure that funds are available within each district throughout the state fiscal year. The chief juvenile court officers and the department shall monitor the availability of the graduated sanction services funds to ensure that the funds are available within each district throughout the state fiscal year.

a. The department shall provide to each court accountant auditor at the start of each state fiscal year a blank electronic report, known as the "Y" form, as well as a spreadsheet showing the amount of the district's allocations for graduated sanction services.

b. The state court administrator shall determine and provide to each district at the start of each state fiscal year the amount of the district's allocation for court-ordered services.

c. Each court accountant auditor shall:

(1) Enter the beginning annual allocation on the "Y" form for court-ordered services and for each graduated sanction service;

(2) Enter on the "Y" form each month the monthly expenditures and transfers of funds to and from each service; and

(3) Submit each month to the department's division of fiscal management the "Y" form showing the monthly balance of service funds, as well as the cumulative expenditures and fund transfers for each service for the district.

d. The department shall:

(1) Use the information provided by each court accountant auditor to prepare each month an electronic report, known as the Form Y Summary, showing the statewide balance of service funds, as well as the cumulative expenditures and fund transfers for each service for each district; and

(2) Distribute the Form Y Summary monthly to the state court administrator and to department and juvenile court services management.

e. The chief juvenile court officers, in consultation with the department or the state court administrator, shall reallocate funds as needed to ensure the availability of graduated sanction services and court-ordered services on a statewide basis throughout the state fiscal year.

f. If funding for either graduated sanction services or court-ordered services is exhausted in any district, the respective services within that district shall be discontinued.

441—151.3(232) Administration of juvenile court services programs within each judicial district. Each chief juvenile court officer is responsible for the administration of the court-ordered services and graduated sanction services within the judicial district. The chief juvenile court officer shall purchase court-ordered services and graduated sanction services on behalf of eligible children within the judicial district.

151.3(1) *Planning for service needs.*

a. Each chief juvenile court officer shall develop a process for determining:

(1) The service needs of the children within the district; and

(2) The mix of services to be provided to best meet the identified needs within the district.

b. Each chief juvenile court officer and service area manager shall develop, sign, and implement an annual plan for prioritizing and allocating decategorized funds within each department service area. The plan shall be known as the child welfare and juvenile justice plan.

c. Each chief juvenile court officer shall develop procedures to evaluate and improve the quality and effectiveness of the services being provided. The chief juvenile court officer shall make recommendations concerning changes in the child welfare system that are needed to ensure that children and families receive the services necessary to meet their unique needs. These recommendations may be incorporated into the annual child welfare and juvenile justice plan.

151.3(2) *Eligible providers.* The chief juvenile court officer shall purchase court-ordered services or graduated sanction services from public or private agencies, organizations, or eligible individuals. To be eligible to provide services, an individual shall meet one of the following criteria:

a. Have a federal identification number; or

b. Have a social security number for which the state accounting enterprise has determined that an employee/employer relationship with the state does not exist; or

c. Be paid an amount during a state fiscal year that does not exceed $1,000 plus allowable expenses such as meals, lodging, and mileage per state fiscal year as determined according to state accounting enterprise procedure 240.102.

151.3(3) *Allowable costs.* The administrative and program requirements of this chapter include those costs specified below:

a. Reimbursement for mileage, meals, and lodging expenses involved in the transportation of the child shall not exceed the lower of the rates set by the state executive council or the provider's customary rate, unless the transportation is provided by a public officer or employee. A public officer or employee, other than a state officer or employee, is entitled to be paid for expenses as specified in the Iowa Code in an amount as determined:

(1) By the public officer's or employee's local governing board when the court order specifies that the public officer or employee is to provide the transportation. The allowable expenses for which sheriffs may be reimbursed are found at Iowa Code sections 70A.9 and 331.655.

(2) By the chief juvenile court officer when the court order does not specify that the public officer or employee is to provide the transportation.

b. For Medicaid-covered services, the provider shall be reimbursed at the same rate and duration as Medicaid reimburses under the fee schedule provided in 441—subrule 79.1(2) unless the chief juvenile court officer determines that a rate negotiated with the provider may be paid.

c. A provider with a purchase of service contract for a similar service shall be reimbursed at the rate of the purchase of service contract. A provider that does not have a purchase of service contract shall be reimbursed at a rate comparable to the rate reimbursed to providers that have purchase of service contracts.

d. Private insurance allowances may be supplemented up to, but shall not exceed, the amounts allowed in this subrule. Funds for court-ordered care and treatment or graduated sanction services shall not be used in lieu of private insurance.

e. A provider shall not be reimbursed at a rate that is greater than that allowed by administrative rules. Reimbursement paid to a provider shall be considered paid in full unless the county voluntarily agrees to pay the difference between the reimbursement rate and the actual costs of the service. When there are specific program regulations prohibiting supplementation, such as the prohibition of supplementation of Medicaid reimbursement, those regulations shall be applied to providers requesting supplemental payments.

151.3(4) *Record keeping.* The provider and juvenile court services shall maintain financial and service records for a period of five years following termination of services. The records are subject to audit.

a. Each provider shall maintain all the financial and service records used to submit or substantiate claims for reimbursement, including court orders as required and lists of the children served. The provider bears ultimate responsibility for the completeness and accuracy of the claim submitted as set forth in these rules.

b. Each provider shall maintain all the corresponding service and financial information necessary to document the provision of the service as agreed upon in the contract. When the contract identifies units of service to be provided, each provider shall maintain a case record or case file that documents the provision of the units of the contracted service for each individual child for whom a claim is made.

c. Each juvenile court officer shall maintain a case record for each child referred for graduated sanction service. Each juvenile court officer shall maintain a case file for each child who receives an ongoing service. The case record or case file shall include all the corresponding service information necessary to document that the contracted service was provided.

d. Each chief juvenile court officer shall ensure that an original court order supports the payment of any claim paid for court-ordered services.

e. Each chief juvenile court officer shall ensure that the district is accountable for payments, receipts, and retention of records as described in subrule 151.4(7).

151.3(5) *Access to records.* Each provider of court-ordered services or graduated sanction services shall make available upon request to juvenile court services, the department, the department of inspections and appeals, or the state auditor the service and financial records used to support or substantiate claims for reimbursement, including court orders and lists of children. The records shall be subject to audit by juvenile court services, the department, the department of inspections and appeals, or the state auditor.

441—151.4(232) Billing and payment. The chief juvenile court officer shall ensure that billing and payment are in compliance with department requirements and the requirements of the accounting policies and procedures manual of the department of administrative services, state accounting enterprise. A claim that meets the requirements of this chapter becomes a state liability on the date of a claim's accrual. The date of a claim's accrual is the date the service was provided, the end of the agreed-upon billing interval specified in the contract, or the date of a determination of liability for the claim.

151.4(1) *Claim forms and instructions.* The instructions and forms used for billing shall be available to the provider from each chief's juvenile court services office. Electronic versions of all forms are available.

a. Court-ordered services.

(1) The provider shall prepare a claim for court-ordered services on Form GAX, General Accounting Expenditure, and Form 470-1691, Claim for Juvenile Court Services Programs, or a facsimile thereof. An original, itemized invoice may be substituted for Form 470-1691.

(2) The provider shall attach a copy of the applicable court order with each initial claim for court-ordered services. Each subsequent claim shall include the first page of the applicable court order, or the case number of the applicable court order shall be entered on Form GAX or Form 470-1691.

b. *Life skills, supervised community treatment, and tracking, monitoring, and outreach.*

(1) The provider shall prepare a claim for life skills, supervised community treatment, and tracking, monitoring, and outreach on Form GAX, General Accounting Expenditure.

(2) The provider shall also submit Form 470-1691, Claim for Juvenile Court Services Programs, a facsimile thereof, an original, itemized invoice, or a copy of the provider's list of the children for whom the claim is made. The document submitted shall include the name of each child and the number of units of service provided to that child each month.

c. *School-based supervision.* The provider shall prepare a claim for school-based supervision on Form GAX, General Accounting Expenditure.

151.4(2) *Preparation of claim.* Form GAX, General Accounting Expenditure, shall be submitted with all claims. The Form GAX submitted shall not include claims for more than one fiscal year. The provider, as vendor, must enter on Form GAX:

a. The vendor code,

b. The vendor's name and mailing address,

c. The vendor's invoice date and number,

d. A short description of the item or service that was purchased,

e. Either the provider's social security number, federal identification number, or tax identification number, and

f. An original signature of the provider unless an original invoice is submitted.

151.4(3) *Support of claim.* The provider bears ultimate responsibility for the completeness and accuracy of each claim submitted. The provider must maintain a record of the days and times during which each service was provided for each child. The provider's record must correspond to the units billed.

151.4(4) *Submittal of claims to juvenile court services.* Providers shall submit claims to the chief juvenile court officer in the judicial district in which the service was provided. The provider shall submit the original Form GAX and any required supporting documents to the chief juvenile court officer for each claim.

a. Claims shall be submitted timely to allow the chief juvenile court officer to submit the claim to the department within 90 calendar days of the date of the claim's accrual.

b. To ensure payment from funds appropriated for the fiscal year, claims shall be submitted timely to allow the chief juvenile court officer to submit the claim to the department within 45 calendar days of fiscal year end, June 30.

151.4(5) *Review and approval of claims.* The chief juvenile court officer is responsible for accuracy and disposition of claims. The chief juvenile court officer shall verify the accuracy of the provider's billings and approve the claims.

a. Juvenile court services may complete Form GAX when the provider submits an original invoice or may enter the following information on Form GAX when the provider has omitted it from the form:

(1) The name and mailing address of the agency or individual providing the services.

(2) A short description identifying the specific services or item purchased. The description will be entered on the warrant sent to the provider.

b. To approve the claim, the chief juvenile court officer or designee shall sign Form GAX in the space titled, "order approved by." The signature shall be deemed as certification that the billed expenses were incurred, that the amounts are correct, and that payment should be made by the department.

151.4(6) *Juvenile court services submittal of claims to department.* The chief juvenile court officer shall prepare and submit claims to the department. Juvenile court services shall make the required number of copies for submittal and shall submit the required documents to the Department of Human

Services, Division of Fiscal Management, Bureau of Purchasing, Payments and Receipts, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The documents required to be submitted are as follows:

a. *New contract.* For the first claim submitted for a new contract, juvenile court services must submit:

(1) Two copies of the signed contract.

(2) Three copies of Form 470-0022, Pre-Contract Questionnaire.

(3) The original and two copies of Form GAX, showing the contract number.

b. *Ongoing contract.* For subsequent claims for contract payment, juvenile court services shall submit the original and two copies of Form GAX, which shall include the following information:

(1) The contract number.

(2) The warrant number.

(3) The paid date, which is the date the first claim was processed through the I-3 system and is stamped on the first warrant the provider receives through the contract.

(4) The reference document number of the initial voucher of the series to which the contract is attached (the reference document number is the 11-digit number listed under "Departmental Reference Numbers" on the warrant, starting with "413-").

(5) The payment number of the total contracted sequence, if known, such as "payment 7 of 12 payments."

c. *Contract amendment.* For each contract amendment, juvenile court services must submit:

(1) The original and two copies of Form GAX;

(2) Two copies of the signed amendment; and

(3) Three copies of Form 470-0022, Pre-Contract Questionnaire.

151.4(7) *Claim records.* The chief juvenile court officer shall have responsibility for retention of records, maintenance of records, and authorized access to records.

a. Juvenile court services shall retain one copy of the claim and supporting documentation as submitted to the department as well as any additional required supporting documentation submitted to juvenile court services by the provider. The copy of Form GAX and supporting documentation, as submitted to the department, as well as any additional required supporting documentation submitted to juvenile court services by the provider, are subject to audit.

b. Each chief juvenile court officer shall establish a system for retention of the records in an organized, audit-friendly manner. During the required retention period, the records and knowledgeable personnel must be accessible and available for the audit. All documents related to each other must be appropriately attached and organized in a manner that provides easy access.

151.4(8) *Claim payment.* The department shall reimburse providers for contract costs when claims are submitted according to the required procedures.

a. The bureau of purchasing, payments and receipts of the division of fiscal management shall process a claim through the state appeal board's administrative process for approving outdated invoices when the department receives the claim:

(1) More than 90 calendar days after the date of its accrual; or

(2) More than 45 calendar days after the date of its accrual at fiscal year end, June 30.

b. If the claim cannot be processed through the state appeal board's administrative process for approving outdated invoices, the claim must be submitted to the state appeal board for approval.

441—151.5(232) Appeals. If services are court-ordered, children who have been adversely affected by decisions made by juvenile court and their parents or guardians may appeal through procedures established pursuant to Iowa Code section 232.133.

441—151.6(232) District program reviews and audits. Each chief juvenile court officer shall establish procedures to review and audit the provision of the graduated sanction services to ensure that the requirements of this chapter and the contracts are met. The court accountant auditor as established according to subrule 151.2(2) shall conduct the reviews and audits.

151.6(1) *Schedule.* The department shall notify each chief juvenile court officer or designee of the providers for which a review and audit must be conducted. The department shall identify in the notice all other judicial districts that have a contract with the provider.

a. Annual on-site reviews and audits are required for any provider having one or more contracts with one or more judicial districts when the total annual value of the contracts is $100,000 or more.

b. An on-site review and audit are required for each provider new to the district during the first year of the provider's contract with the district when the total annual value of the provider's contracts with the judicial district is $50,000 or more.

c. Additional on-site reviews and audits are optional but may be considered appropriate by the chief juvenile court officer for providers, other than those described in paragraphs *"a"* and *"b,"* based on factors such as:

(1) Length of time provider has been in business.

(2) Amount of time provider has offered the services being purchased.

(3) Type of service or program being purchased.

(4) Amount of money involved in the contract.

(5) Whether other governmental entities contract with this provider.

(6) Findings from previous audits by the district, the department, or other entities such as the state auditor's office.

151.6(2) *Location.* The reviews and audits shall take place at the sites where the program is operated and where necessary program and fiscal records are maintained.

151.6(3) *Scope.* The court accountant auditor shall review and audit the provider's service and financial records, including the client case records and case files, to ensure that the records contain the required documentation of the provision of the contracted service for each individual child for whom a claim is made. The reviews and audits shall include:

a. Contact with the client.

b. Review and audit of service billings and delivery of service.

c. Review and audit of provider standards, staff qualifications, case files and case records, progress reports, and billing and payment records.

151.6(4) *Repayment.* The chief juvenile court officer may seek repayment of claims paid for noncovered services or for services for which documentation is not established.

a. The chief juvenile court officer shall notify the provider in writing that a repayment is due. The written notice shall identify:

(1) The claims;

(2) The amounts of the claims that are not documented or substantiated; and

(3) The amount of the repayment requested.

b. The provider shall repay the department the difference between the amount received and the amount established through the audit, not to exceed the amount paid by the state, when:

(1) The provider, upon audit, fails to verify or document the provision of covered services or costs in the amount for which a claim was paid or when the audit confirms claims paid for noncovered services; and

(2) Juvenile court services or the department makes a request for repayment.

c. The provider shall repay the department for the amount of any claims not supported by audit when:

(1) The provider fails to maintain adequate records for auditing purposes or fails to make records available for audit or when the records, upon audit, fail to support the claims submitted; and

(2) Juvenile court services or the department makes a request for repayment.

d. A provider that is adversely affected by the request for repayment may appeal using procedures established in 441—Chapter 7.

e. If the provider does not make payment within 45 days, the chief juvenile court officer shall submit to the department a copy of the notice to the provider for the department's review and further action if necessary.

151.6(5) *Report.* Each chief juvenile court officer shall submit to the department an annual report of the district's review and audit activities for each state fiscal year.

a. The annual report shall be submitted by December 31 following the end of the state fiscal year. This date may be extended upon the written request of the chief juvenile court officer to the department.

b. The annual report shall include a report of the results of the review and audit for each required audit as well as a summary of the findings of the reviews and audits conducted on any other providers receiving state or federal funds in the state fiscal year.

These rules are intended to implement Iowa Code section 232.141.

441—151.7 to **151.19** Reserved.

DIVISION II
COURT-ORDERED SERVICES

PREAMBLE

These rules prescribe the responsibilities of the chief juvenile court officers and the department of human services for the administration of court-ordered services. In addition, these rules prescribe a list of expenses that are eligible for reimbursement and a list of expenses that are ineligible for reimbursement. The lists are intended to be exhaustive.

441—151.20(232) Juvenile court services responsibilities. The chief juvenile court officer shall purchase court-ordered services for eligible children pursuant to the authority of a court order and the certification of the court.

151.20(1) The chief juvenile court officer shall have the opportunity to establish the availability of funds before a request for court-ordered services is presented to the court.

151.20(2) Any services that are provided without the signed approval of the chief juvenile court officer or the chief juvenile court officer's designee may be denied payment, unless there is an emergency or after-hours situation and no other provision exists for handling emergency or after-hours situations or transports.

151.20(3) A district or juvenile court shall not order any service that is a charge upon the state pursuant to Iowa Code section 232.141 if there are insufficient court-ordered services funds available in the district court distribution amount to pay for the service.

151.20(4) The chief juvenile court officer shall encourage use of the funds in the district's fiscal year fund allocation such that there are sufficient funds during the entire year to pay for all court-ordered services.

a. The chief juvenile court officer shall establish service priorities for spending the court-ordered services funds allocated to the district.

b. The chief juvenile court officer shall inform the state court administrator of potential shortfalls in the district's distribution amount and shall request the state court administrator to transfer funds between the districts' distribution amounts as prudent.

c. The chief juvenile court officer shall notify the state court administrator and the chief judge of the district in the event that the court-ordered services funds for the judicial district are exhausted.

441—151.21(232) Certification process. The chief juvenile court officer shall determine the certification of the court for each ordered service.

151.21(1) *Application for court-ordered services.* Any party intending to request court-ordered services funds shall complete an application and receive approval for the funding request from the chief juvenile court officer before making the request to the court.

a. The application form with instructions shall be available upon request from the office of each chief juvenile court officer.

b. The applicant shall have verified that there are no other alternative funding sources for the service.

c. The chief juvenile court officer may establish procedures for handling emergency or after-hours situations and for the handling of transports.

151.21(2) *Determination.* The chief juvenile court officer shall determine whether the requested service is eligible for reimbursement and shall certify that there are sufficient funds available to pay for the service. The chief juvenile court officer shall determine whether:

a. The requested service falls within the court-ordered services expenses defined in Iowa Code section 232.141, subsections (4) and (5), and subrule 151.22(1); and

b. There are sufficient funds in the district's fiscal year fund allocation to pay for the requested service.

151.21(3) *Use of other funding sources.* The department, in cooperation with the chief juvenile court officers, shall ensure that the funds allocated for court-ordered services are spent only after all other reasonable actions have been taken to use other funding sources. Services are not eligible for reimbursement when another payment source is available.

a. Medicaid. The department shall maximize the use of funds that may be available from the Medicaid program, including coverage for early and periodic screening, diagnosis, and treatment and for psychiatric medical institutions for children (PMIC), before requesting assistance through the court-ordered services fund. However, medical cost sharing for the one-time payment per court order of a deductible amount or a coinsurance amount for treatment specified in a court order is an allowable expense that may be paid through the court-ordered services fund when insurance or Medicaid is then available to pay the remainder of the cost.

b. Other third-party payments. The department shall recover payments from any third-party insurance carrier that is liable for coverage of the services, including health insurance coverage. The department shall submit claims to third-party insurance carriers liable for coverage of the services before the claims are submitted for payment through the court-ordered services fund.

c. The date of a medical claim's accrual for reimbursement through court-ordered services is the date the claim becomes a state liability. For example, a claim becomes a state liability on:

(1) The date of a court order for a contested claim; or

(2) The date of a determination by Medicaid or private insurance that Medicaid or private insurance denies partial or full payment for care and treatment for which an application has been made.

d. If eligible for reimbursement through the court-ordered services fund, medical claims that are submitted to, but are denied by, Medicaid or private insurance shall be paid at a rate not to exceed the rate set by Medicaid.

151.21(4) *Certification.* The chief juvenile court officer or designee shall approve or disapprove the request for funds and shall sign and return the application to the applicant.

a. If the request is disapproved, the applicant must approach another service.

b. If the request is approved, the service plan may be presented to the court for a court order to be issued for the services.

151.21(5) *Allowable rates not available.* When the department has been unable to establish an allowable rate of reimbursement for a service or a provider, the chief juvenile court officer shall negotiate a reimbursement rate with the provider to obtain the service at a reasonable cost based on available community or statewide rates.

441—151.22(232) Expenses. The following lists of expenses that are either eligible or ineligible for reimbursement from the court-ordered services fund are intended to be exhaustive. Billings for services not listed in subrule 151.22(1) shall not be paid except as provided in subrule 151.22(3).

151.22(1) *Expenses to be reimbursed.* The expenses for which reimbursement shall be made include:

a. Expenses, other than salary, incurred by a person ordered by the court, other than a juvenile court officer, in transporting a child to or from a place designated by the court, including mileage, lodging and meals.

b. The expense of care or treatment ordered by the court whenever the minor is placed by the court with someone other than the parents; or a minor is given a physical or mental examination or treatment under order of the court; or, upon certification by the department, a minor is given physical or mental examinations or treatment with the consent of the parent, guardian or legal custodian relating to a child abuse investigation and no provision is otherwise made by the law for payment for the care, examination, or treatment of the minor. Care and treatment expenses for which no other provision for payment is made by law that shall be reimbursable include court-ordered:

(1) Individual services for the child separate from a family's treatment plan.

(2) Diagnosis and evaluation on an outpatient basis unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for that service for which the child is eligible.

(3) An evaluation of a child in a residential facility.

(4) Inpatient (hospital) evaluation of a child previous to disposition.

(5) Medical treatment for a child. This includes medical treatment while in detention in a facility used for detention when the medical treatment is court-ordered.

(6) Drug treatment, testing and care for a child.

(7) Intensive in-home supervision and monitoring and alternatives to shelter care unless a person or agency that has a contract with the department provides the service for which the child is eligible.

(8) Evaluation of parents pursuant to a CINA adjudication unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for that service for which the child is eligible.

(9) One-to-one supervision of a child not in a detention facility unless the service is provided by a person or agency with a contract with the department for that service for which the child is eligible.

(10) Physical or mental examinations ordered pursuant to Iowa Code section 232.49 or 232.98 except those set forth in paragraph 151.22(2)*"c"* or those eligible for payment pursuant to Iowa Code chapter 249A.

(11) Services ordered under family in need of assistance proceedings unless a person or agency with a contract with the department provides the service for which the child is eligible.

(12) Expenses for all educational testing or programming for children, not weighted as special education students, who attend an on-campus school in an out-of-state facility.

(13) Expenses for educational testing or programs related to a general equivalency diploma (GED) or for credit hours, when the expenses are not required to be paid by the state.

c. Medical cost sharing for payment of one deductible amount or a coinsurance amount when Medicaid or private insurance is then available to pay the remainder of the cost.

151.22(2) *Expenses not reimbursed.* Expenses that are excluded from reimbursement from court-ordered services funds because another source is available to pay for the service include:

a. Foster care (including shelter care). Payment provision is Iowa Code section 234.35.

b. All charges for which the county is obligated by statute to pay including:

(1) Care and treatment of patients by any state mental health institute. Payment provision is Iowa Code section 230.20(5).

(2) Care and treatment of patients by either of the state resource centers or by any other facility established under Iowa Code chapter 222. Payment provision is Iowa Code section 222.60.

(3) Care and treatment of patients by the psychiatric hospital at Iowa City. Payment provision is Iowa Code chapter 225.

(4) Care and treatment of persons at the alcoholic treatment center at Oakdale or any other facility as provided in Iowa Code chapter 125. Payment provision is Iowa Code section 125.44.

(5) Care of children admitted or committed to the Iowa juvenile home at Toledo. Payment provision is Iowa Code section 233B.14.

(6) Clothing, transportation, and medical or other service provided to persons attending the Iowa Braille and Sight-Saving School, the Iowa School for the Deaf, or the state hospital-school for severely handicapped children at Iowa City for which the county becomes obligated to pay pursuant to Iowa Code sections 263.12, 269.2, and 270.4 to 270.7.

(7) Expenses for detention in a facility used for detention. The payment provision is Iowa Code section 232.142.

(8) Care and treatment of persons placed in the county hospital, county care facility, a health care facility as defined in Iowa Code section 135C.1, subsection 6, or any other public or private facility in lieu of admission or commitment to a state mental health institute, resource center, or other facility established pursuant to Iowa Code chapter 222. Payment provisions are Iowa Code sections 222.50, 230.1 and 233B.14.

c. Child-abuse photos and X-rays. Payment provision is Iowa Code section 232.77.

d. Any expenses set forth in subrule 151.22(1) above, which qualify for payment pursuant to Iowa Code chapter 249A.

e. Expense of a child sexual abuse examination. Payment provision is Iowa Code section 915.41.

f. Expense of child day care. Payment provision is Iowa Code section 234.6.

g. Expense of in-home treatment services. Payment provision is 441—Chapters 78, 79, and 83.

h. Expense of homemaker-home health aide services. Payment provision is department of public health rules 641—Chapter 80.

i. Expenses for all educational testing or programming required to be paid by the state, except for juveniles who attend an on-campus school in an out-of-state facility and who are not weighted as special education students. The payment provision is Iowa Code chapter 256.

j. Expenses, except for the allowable medical cost sharing, for all court-ordered counseling and treatment for adults, including individual, marital, mental health, substance abuse and group therapy. The payment provision is private insurance, Medicare, Medicaid, or other resources consistent with Medicaid and social services eligibility and Iowa Code chapter 249A.

k. Expenses, except for the allowable medical cost sharing, for psychiatric medical institutions for children (PMIC). The payment provision is private insurance, Medicare, Medicaid, or other resources consistent with Medicaid and social services eligibility and Iowa Code chapter 249A.

151.22(3) *Services not listed.* If a court orders a service not currently listed in subrule 151.22(1), the chief juvenile court officer shall review the order and shall consult with the department. If reimbursement for the service expense is not in conflict with current law or administrative rules and meets the criteria for certification of the court, the chief juvenile court officer shall authorize reimbursement to the provider.

These rules are intended to implement Iowa Code section 232.141.

441—151.23 to **151.29** Reserved.

DIVISION III
GRADUATED SANCTION SERVICES

PREAMBLE

The graduated sanction services are early intervention and follow-up services to be provided to children adjudicated delinquent and to children who have been referred to juvenile court services for a delinquency violation or who have exhibited behaviors likely to result in a juvenile delinquency referral. The services are directed to enhance personal adjustment to help the children transition into productive adulthood and to prevent or reduce criminal charges, out-of-home placement, and recidivism. The services are provided in the child's home community.

The graduated sanction services are life skills, school-based supervision, supervised community treatment, and tracking, monitoring, and outreach. Together this mix of services and the flexibility allowed in tailoring the services to meet specific needs offer a choice of treatment to meet the specific needs of the child.

441—151.30(232) Life skills. "Life skills" means individual or group instruction which includes, but is not limited to, specific training to develop and enhance personal skills, problem solving, accountability, acceptance of responsibility, victim empathy, activities of daily living, and job skills.

151.30(1) *Service eligibility.* Children shall be eligible for life skills services without regard to individual or family income when they are adjudicated delinquent or are determined by a juvenile court officer to be at risk and to be in need of the service provided by a life skills program. Juvenile court services shall maintain in the child's case record or case file documentation of the child's adjudication or at-risk status as well as the child's need for services.

a. The chief juvenile court officer shall establish written procedures for screening and approving referrals for life skills services and make the procedures available to the district's juvenile court officers.

b. The juvenile court officer shall determine the child's need for individual or group instruction in any of the life skills service components and shall refer the child for the service.

c. The chief juvenile court officer may approve life skills services for up to six consecutive months at a time, except that service approval shall not extend beyond the current fiscal year unless a contract is in effect to assume the cost for the services provided in the next fiscal year. The officer shall reevaluate the child's eligibility and need for these services in accordance with procedures established by the respective juvenile court services district.

d. Referrals shall not be made or accepted when funds for the program are not available.

151.30(2) *Service components.*

a. Life skills components include specific training to develop and enhance:

(1) Personal skills, including anger management, stress reduction, and self-esteem.

(2) Rescinded IAB 11/9/05, effective 1/1/06.

(3) Problem solving.

(4) Accountability and acceptance of responsibility.

(5) Victim empathy.

(6) Activities of daily living.

(7) Job skills including job-seeking skills as well as training for specific jobs and on-the-job training experiences.

b. The contract must specify what is required of the provider.

151.30(3) *Service referral and follow-up.* The juvenile court officer shall:

a. Determine which service provider can best meet the child's needs.

b. Refer the child to the provider.

c. Assist in the child's transition to receive the service.

d. Follow up after the service has been provided.

151.30(4) *Monitoring of service delivery.* The juvenile court officer shall monitor the delivery of life skills services to children for whom the officer is responsible.

a. The juvenile court officer shall review provider progress reports and maintain contact with the child, the child's family, the provider, and other community agencies to adequately assess the child's progress and need for service.

b. The juvenile court officer shall report problems in service delivery to the chief juvenile court officer.

c. The provider, the child, or the child's representatives may report problems in service delivery to the chief juvenile court officer.

151.30(5) *Billable unit and rate setting.* Rates for life skills services shall be established through an agreement between the provider and the chief juvenile court officer based on the provider's proposed budget. Rates may vary among providers for various types of life skills services. The billable unit and unit costs shall be specified in the contract.

a. Life skills service shall be billed on the basis of units of instruction provided to eligible children during specified time frames.

b. The life skills instruction may be provided on an individual or group basis. See paragraph 151.35(2)*"c"* for rate-setting requirements when more than one child is served at a time.

c. The provider may incorporate the expenses for instructional materials into the service unit cost or may identify the expenses for instructional materials in an attachment to the contract to be billed separately from the unit cost.

d. Rescinded IAB 11/9/05, effective 1/1/06.

151.30(6) *Provider standards.* Providers shall have a contract with juvenile court services and the department for life skills services and agree to abide by all required instructional, reporting, rate-setting, and billing and payment procedures for life skills services. The chief juvenile court officer shall review provider staff qualifications and training activities. Providers of life skills services shall meet all of the following conditions. Providers shall:

a. Be selected and approved by the chief juvenile court officer or designee within each judicial district to provide life skills services.

b. Use staff who, in the opinion of the chief juvenile court officer, have the necessary training and experience to provide quality services on the topic about which they will be delivering instruction.

c. Use a curriculum approved by the chief juvenile court officer for life skills.

d. Have the educational and instructional ability, as determined by the chief juvenile court officer, to deliver life skills services to eligible children in the settings most suited to each child's needs.

151.30(7) *Provider progress reports.*

a. Providers of life skills shall submit progress reports on each child receiving services to the assigned juvenile court officer at intervals specified in the contract. The contract shall specify progress reports not more than one month after services are initiated and at the termination of service. Progress reports shall describe the specific instruction provided, the child's attendance, response to instruction, and progress toward achieving desired goals and objectives identified by the provider and referral source.

b. The juvenile court officer shall file the provider progress report in the child's case file.

c. Rescinded IAB 11/9/05, effective 1/1/06.

151.30(8) *Outcome measures.* Each contract for purchase of life skills services shall contain a section to inform the provider that juvenile court services and the department shall track the outcome of the service provision following each child's discharge from the service received through the contract.

a. Juvenile court services and the department shall collaborate to determine the criteria and data needed to track and record the outcomes.

b. The provider shall report data as requested by juvenile court services.

c. Juvenile court services shall determine whether the child has reoffended within the 12-month period following the date of discharge from life skills. Service to a child shall be considered successful if the child has not been referred to juvenile court services for a law violation during the 12-month period following discharge from life skills.

d. Data collected on the children served and discharged shall be used to establish or modify a baseline for the provider and for the service. The data shall be used to develop information to make decisions regarding service provision and contracting.

441—151.31(232) School-based supervision. "School-based supervision" means a program that provides for salaried staff, known as juvenile court school liaisons, to be hired by providers. The juvenile court school liaisons provide on-site services at middle and high schools to children experiencing truancy or other behavior problems at school and at home or in the community.

151.31(1) *Service eligibility.*

a. Children shall be eligible for school-based supervision services without regard to individual or family income when they are adjudicated delinquent or adjudicated a child in need of assistance or are determined by a juvenile court officer or school official to be at risk and in need of school-based supervision services. Documentation of the adjudication or at-risk status as well as the need for services shall be maintained by the juvenile court school liaison in the child's case record or case file.

b. The chief juvenile court officer shall establish written procedures for screening and approving referrals for school-based supervision services. The written procedures for screening and approving referrals shall be made available to the juvenile court school liaisons and to the district's juvenile court officers.

c. Referrals shall not be made or accepted when funds for the program are not available.

151.31(2) *Service components.*

a. Juvenile court school liaisons assist with behavior and classroom management, conflict resolution, school attendance, and violence prevention. Services provided may include, but are not limited to, dealing with misbehavior and truancy on an immediate basis, providing family support services such as outreach and education, performing juvenile court intake functions under the supervision of the chief juvenile court officer, and promoting resource development to meet most effectively the needs of at-risk youth.

b. Each school-based supervision program shall have established procedures for communication and for maintaining records on individual children receiving assistance. The procedure shall include methods for the timely communication of critical information between juvenile court school liaisons and juvenile court services, the department, and school officials; assurances that child abuse allegations shall be reported promptly in accordance with applicable Iowa statutes; and systems to safeguard the confidentiality of the child's records.

151.31(3) *Service referral and follow-up.* The juvenile court officer, department staff, or school personnel shall:

a. Determine when a service referral should be made to best meet the child's needs.

b. Refer the child to the provider.

c. Assist in the child's transition to receive the service.

d. Follow up after the service has been provided.

151.31(4) *Monitoring of service delivery.*

a. The juvenile court officer and school personnel shall monitor the delivery of school-based supervision services to children for whom the officer is responsible.

b. The juvenile court officer and school personnel shall report problems in service delivery to the chief juvenile court officer.

c. The juvenile court school liaison, the child, or the child's representatives may report problems in service delivery to the chief juvenile court officer.

151.31(5) *Billable unit and rate setting.* The school-based supervision program is used to hire salaried staff, through a contract with a provider, to provide school-based supervision. The cost of the service is the cost of the salary and administrative expenses identified in the contract for which the department is billed, generally monthly or quarterly.

a. The contract shall define the rate and schedule to be used for submitting a claim for salary and related administrative expenses.

b. School-based supervision provides short-term or long-term service to children. The juvenile court school liaison shall maintain a list (roster), by month, of the individual children to whom service is provided. The juvenile court school liaison shall have face-to-face or verbal contact with each child whose name appears on the roster. The list shall include the name of the child and the referral source.

(1) The school shall maintain a copy of the list and the claim. Each claim is validated by the list of children served during each month the school is in session. The list and the claim are subject to audit.

(2) The juvenile court school liaison is not required to list the names of children receiving group services.

(3) The juvenile court school liaison and school are not required to maintain or submit lists of children served for those months covered by a school employee contract for which the salary is prorated when school is not in session and no service is provided. The prorated salary arrangement shall be described in the contract.

c. School-based supervision rates are based on directives in annual legislation for the school-based appropriation as well as budget and rate-setting procedures within each school district. Funds allocated to the department and administered by juvenile court services shall be matched with funds committed from the local school district where the program is established. The chief juvenile court officer shall negotiate the match rate with the school board's authorized designee.

(1) The amount of dollars each chief juvenile court officer may use for school-based supervision is equal to the judicial district's current school-based supervision allocation plus an amount from the

court-ordered services allocation. The total amount available from the court-ordered services allocation is equal to 50 percent of the school-based supervision allocation available for state fiscal year 1998 or $580,000. The state court administrator shall determine the amount from the court-ordered services allocation available to each district each year based on each district's respective portion of the statewide population of children as reported in current census data.

(2) The chief juvenile court officer shall transfer an amount, as necessary and allowable, to the school-based supervision allocation from the court-ordered services allocation so that the school-based supervision share of the program cost of each contract equals the agreed-upon match amount for each contract.

(3) The contract shall specify the maximum percentage of the program cost that shall be paid from the school-based supervision funds as well as the minimum percentage of the program cost that shall be paid by the school district.

151.31(6) *Selecting schools for programs.* The chief juvenile court officer of each judicial district shall be responsible for selecting school-based programs for funding and for managing the judicial district's school-based supervision allocation to ensure that resources are targeted effectively among schools within the district. All applications for funding and subsequent contracts shall contain funding commitments from the local school district for the local school district's share of program costs.

a. The chief juvenile court officer may elect to develop an intergovernmental 28E agreement with the school district, or the school district may request that a contract be developed with an independent provider pursuant to a competitive bid.

b. The funding arrangements shall be described in the contract.

c. Each contract shall contain:

(1) A description of the school district and specific schools in which the supervision program shall be implemented, including a description of why these schools were targeted as needing the program.

(2) A description of the proposed school-based supervision program to be implemented, including the referral process for the child, eligibility determination, service denial, reduction, or termination, and appeal procedures. This description may be included in the contract or may be included as an attachment.

(3) A description of the number of staff to be employed in the program, including the job description, staff qualifications, procedures for training and supervising staff, and methods for monitoring the program. A minimum of a bachelor of arts or a bachelor of science degree in the behavioral sciences or related field is required unless the chief juvenile court officer and the school agree that an associate degree is acceptable.

(4) A description of the record-keeping and statistical reporting procedures to be used by the program.

151.31(7) *Provider progress reports.*

a. School-based supervision programs shall maintain information and statistics that shall include, at a minimum, the service and financial records used to support or substantiate claims for reimbursement and, for the individual children referred for service, the total number of children served as well as educational and behavioral outcomes including attendance, grades, and student conduct.

b. Each school with a school-based supervision program shall prepare a progress report summarizing information about the program and shall submit the report to the chief juvenile court officer. The format and time for submitting these reports shall be specified in the contract.

151.31(8) *Outcome measures.* Each contract shall contain a section to inform the provider that juvenile court services and the department shall track the outcome of the service provision for each child who is served through the contract and meets predetermined contact criteria.

a. Juvenile court services and the department shall collaborate to determine preservice and postservice measures needed to track and record outcomes such as attendance, truancy, tardiness, suspensions, law violations, and grade-point average.

b. The juvenile court school liaison shall report data as requested by juvenile court services.

c. Data collected on the children shall be used to establish or modify a baseline for the provider and for the service. The data shall be used to develop information to make decisions regarding service provision and contracting.

441—151.32(232) Supervised community treatment. "Supervised community treatment" means a program that provides supervised educational support and treatment during the day to children who are experiencing social, behavioral, or emotional problems that place them at risk of group care or state institutional placement. A supervised community treatment program for a child may be funded from multiple sources, but the funding sources for components of the service may not duplicate or overlap payment or service activities so as to pay for the same or parts of the same service twice or pay for overlapping services. A program whose components and activities are funded from multiple sources must be capable of tracking the receipt and expenditure of funds for the components and activities, and these funding streams must be described in the contract.

151.32(1) *Service eligibility.* Children shall be eligible for supervised community treatment services without regard to individual or family income when they are adjudicated delinquent or are determined by a chief juvenile court officer to be at risk and to be in need of service provided by a supervised community treatment program. Juvenile court services shall maintain documentation in the child's case file of the adjudication or at-risk status as well as of the need for services.

a. The chief juvenile court officer shall establish written procedures for screening and approving referrals for supervised community treatment services and shall make the procedures available to the district's juvenile court officers.

b. The juvenile court officer shall determine the child's need for supervised community treatment and shall refer the child for service.

c. The child shall not require more extensive treatment than is provided in the supervised community treatment program.

d. The chief juvenile court officer may approve supervised community treatment services for up to six consecutive months at a time, except that service approval shall not extend beyond the current fiscal year unless a contract is in effect to assume the cost for the services provided in the next fiscal year. The officer shall reevaluate the child's eligibility and need for these services in accordance with the procedures established by the chief juvenile court officer.

e. Referrals shall not be made or accepted when funds for the program are not available.

151.32(2) *Service components.* Supervised community treatment programs provide treatment to children as well as an opportunity for children to participate in state-funded educational programming. Supportive therapy or counseling and skill development services may be provided through this program to the child's family.

a. Supervised community treatment programs may be co-located with school programs. Although the costs of the state-funded educational programming shall not be funded through the supervised community treatment appropriation, programs shall be developed so that there is close coordination between the treatment and the state-funded educational components.

b. Supervised community treatment programs shall include one or more of the following components:

(1) Skill-building services focusing on social skills, recreational activities, employment readiness, independent living, and other areas related to a child's treatment needs.

(2) Individual, group, and family therapy and counseling as determined appropriate by the program director and referral source. Staff that provide individual, group, or family therapy shall meet applicable state licensing standards.

(3) Snacks and meals as necessary during the non-state-funded educational portion of the program day.

(4) Supervision and support services, such as transportation to the non-state-funded educational program, family outreach, telephone contact, and electronic monitoring of children.

(5) Aftercare service planning upon admission, so that timely aftercare services are available upon discharge, if needed.

(6) Supervision and support services when necessary to help children transition out of the program.

c. The contract must specify the responsibilities of the provider.

151.32(3) *Service referral and follow-up.* The juvenile court officer shall:

a. Determine which service provider can best meet the child's needs.

b. Refer the child to the provider.

c. Assist in the child's transition to receive the service.

d. Follow up after the service has been provided.

151.32(4) *Monitoring of service delivery.* The juvenile court officer shall monitor the delivery of supervised community treatment services to children for whom the officer is responsible.

a. The juvenile court officer shall review provider progress reports and maintain contact with the child, the child's family, the provider, and other community agencies to adequately assess the child's progress and need for service.

b. The juvenile court officer shall report problems in service delivery to the chief juvenile court officer.

c. The provider, the child, or the child's representatives may report problems in service delivery to the chief juvenile court officer.

151.32(5) *Billable unit and rate setting.* Rates for supervised community treatment shall be established through an agreement between the provider and the chief juvenile court officer, based on the provider's proposed budget. The billable unit and costs shall be specified in the contract.

a. Supervised community treatment shall be billed on the basis of units of service provided to eligible children during specified time frames.

b. The supervised community treatment service may be provided on an individual or group basis. See paragraph 151.35(2)*"c"* for rate-setting requirements when more than one child is served at a time.

c. Rates shall be established and reimbursed based on delivery of one-half hour, one hour, or per diem of specified supervised community treatment service.

d. The rate for any supervised community treatment service delivered in the same room by staff with the same qualifications as any other comparable treatment or supportive service program shall be the applicable rate established for the other comparable treatment or supportive services program.

e. Different rates may be established for the different components of the supervised community treatment program, and different sources of payment may be used for the different components.

(1) Provision may be made in the contract for the billing and payment of telephone or transportation costs to be included in the unit cost, or the provider may, in an attachment to the contract, identify the expenses to be billed separately from the unit cost.

(2) Telephone calls may be reimbursed according to receipts or at a set rate per call.

151.32(6) *Provider standards.* Providers of supervised community treatment shall meet all of the following conditions. Agencies or organizations shall:

a. Have a current purchase of services or rehabilitative treatment and supportive services contract with the department.

b. Be selected by the chief juvenile court officer of the judicial district within the geographic area where the program is located to provide supervised community treatment services within all or a portion of the judicial district.

c. Agree to provide services in compliance with the programmatic standards established by the rules of this division.

d. Enter into a contract with juvenile court services and the department that establishes expectations, rates, and billing and payment procedures for the supervised community treatment program.

e. Agree to report supervised community treatment program costs separately on all cost reports.

f. Agree to comply with higher staff qualifications for specific components of these programs when the chief juvenile court officer outlines the expected qualifications in the request for proposal and program contract. In addition:

(1) The minimum standard for staff qualifications for staff employed to deliver services in a supervised community treatment program shall be graduation from high school or possession of a GED certificate and the equivalent of one year of full-time experience in the delivery of human services in a public or private agency.

(2) Providers shall ensure that staff has experience in working with the target population of children and shall provide planned opportunities for ongoing staff development and in-service training.

(3) Staff qualifications shall be monitored by juvenile court services as part of monitoring the contract.

151.32(7) *Provider progress reports.* Providers of supervised community treatment services shall prepare an initial treatment plan in consultation with the referral source within 30 days of the child's admission and shall prepare a minimum of quarterly progress reports on each child receiving services.

a. Additional reports may be prepared when requested by the juvenile judge or the child's juvenile court officer.

b. All reports shall be submitted to the juvenile court officer responsible for monitoring the child's progress. All reports shall, at a minimum, describe the child's attendance, adjustment, and progress in achieving the desired goals and objectives established in the treatment plan.

c. Rescinded IAB 11/9/05, effective 1/1/06.

151.32(8) *Outcome measures.* Each contract shall contain a section to inform the provider that juvenile court services and the department shall track the outcome of the service provision following each child's discharge from the service received through the contract.

a. Juvenile court services and the department shall collaborate to determine the criteria and data needed to track and record the outcomes.

b. The provider shall report data as requested by juvenile court services.

c. The department shall make a determination six months following each child's discharge as to whether the child is in foster family care, group care, or institutional placement. Service to a child shall be considered successful if:

(1) The child is living at home even when less intensive services are provided; or

(2) The child is in supervised apartment living.

d. Data collected on the children served and discharged shall be used to establish or modify a baseline for the provider and for the service. The data shall be used to develop information to make decisions regarding service provision and contracting.

441—151.33(232) Tracking, monitoring, and outreach. Tracking, monitoring, and outreach are undertaken to provide individualized and intensive one-to-one intervention to a child to help the child establish positive behavior patterns and to help the child maintain accountability in a community-based setting.

151.33(1) *Service eligibility.* Children shall be eligible for tracking, monitoring, and outreach services without regard to individual or family income when they are adjudicated delinquent or are determined by a chief juvenile court officer to be at risk and to be in need of assistance in maintaining accountability in a community-based setting. Juvenile court services shall maintain in the child's case record or case file documentation of the child's adjudication or at-risk status and need for services.

a. The chief juvenile court officer shall establish written procedures for screening and approving referrals for tracking, monitoring, and outreach services and shall make the procedures available to the district's juvenile court officers.

b. The juvenile court officer determines the child is in need of services as evidenced by one of the following situations:

(1) Schools, parents or community organizations, due to concerns or reports of delinquent activities, have completed reports that indicate the need for monitoring and guidance of a child.

(2) A petition has been filed alleging delinquent behavior.

(3) Juvenile court services action has been taken including, but not limited to, informal adjustment agreements, adjudication and disposition proceedings.

c. The chief juvenile court officer may approve tracking, monitoring, and outreach services for up to six consecutive months at a time, except that service approval shall not extend beyond the current fiscal year unless a contract is in effect to assume the cost for the services provided in the next fiscal year. The officer shall reevaluate the child's eligibility and need for these services in accordance with procedures established by the respective juvenile court services district.

d. Referrals shall not be made or accepted when funds for the program are not available.

151.33(2) *Service components.* Tracking, monitoring, and outreach services may be provided seven days a week, up to 24 hours a day, and may include multiple daily contacts with the child.

a. The service may include any one component or combination of tracking, monitoring, or outreach components as needed

(1) "Tracking" means observing and following a child's actions.

(2) "Monitoring" means using data from tracking activity to determine that the child's actions include preselected or approved destinations.

(3) "Outreach" means guidance and advocacy.

b. Tracking and monitoring activities are directed toward the child's maintaining accountability and may include multiple daily contacts with the child through direct personal contact, telephone, or electronic monitoring devices.

c. Outreach activities provide guidance and advocacy for the child and may include individualized interventions with the child's family as well as assistance in accessing the following types of resources:

(1) Referral to community organizations.

(2) Health services (physical and mental).

(3) Education.

(4) Employment.

(5) Legal.

(6) Case conferences and services planning.

(7) Diagnostic assessment services.

(8) Family competency-building services.

d. Outreach activities may also include recreation and transportation when guidance and advocacy are a part of the service component.

e. The provider may provide tracking, monitoring, and outreach activities or may provide tracking and monitoring information to the juvenile court officer, who then determines the need for outreach. The contract must specify what is required of the provider.

151.33(3) *Service referral and follow-up.* The juvenile court officer shall:

a. Determine which service provider can best meet the child's needs.

b. Refer the child to the provider.

c. Assist in the child's transition to receive the service.

d. Follow up after the service has been provided.

151.33(4) *Monitoring of service delivery.* The juvenile court officer shall monitor the delivery of tracking, monitoring, and outreach services to children for whom the officer is responsible.

a. The juvenile court officer shall review provider progress reports and maintain contact with the child, the child's family, the provider, and other community agencies to adequately assess the child's progress and need for service.

b. The juvenile court officer shall report problems in service delivery to the chief juvenile court officer.

c. The provider, the child, or the child's representatives may report problems in service delivery to the chief juvenile court officer.

151.33(5) *Billable unit and rate setting.* The unit of service shall be defined as a quarter-hour, half-hour, hour, or day of service to the child, as specified in the contract.

a. The reimbursement rate shall represent actual costs.

b. For telephone contact monitoring, juvenile court services may choose to reimburse providers according to receipts or at a set rate per call.

151.33(6) *Provider standards.* Providers of tracking, monitoring, and outreach shall meet all of the following conditions. Providers shall:

a. Have a current contract with juvenile court services and the department in which they agree to accept the unit rate and agree to provide services in compliance with the programmatic requirements for tracking, monitoring, and outreach services.

b. Be selected by the chief juvenile court officer of the judicial district within the geographic area where the program is located to provide tracking, monitoring, and outreach services within all or a portion of the judicial district.

c. Enter into a contract with juvenile court services and the department that establishes expectations, rates, and billing and payment procedures for the tracking, monitoring, and outreach services.

d. Agree to report tracking, monitoring, and outreach costs separately on all cost reports.

151.33(7) *Provider progress reports.*

a. Providers of tracking, monitoring, and outreach services shall prepare and provide written progress reports at least monthly for each child receiving services for three months or less.

b. Providers of tracking, monitoring, and outreach services shall:

(1) Prepare and provide an initial treatment plan in consultation with the referral source within 30 days of each child's admission for ongoing service activities; and

(2) Prepare and provide written progress reports at least quarterly.

c. Additional reports shall be prepared when requested by the juvenile judge or the child's juvenile court officer. All reports shall be submitted to the juvenile court officer responsible for monitoring the child's progress.

d. All reports for children who receive ongoing service activities shall, at a minimum, describe the child's compliance, adjustment, and progress in achieving the desired goals and objectives established in the treatment plan.

e. Rescinded IAB 11/9/05, effective 1/1/06.

151.33(8) *Outcome measures.* Each contract shall contain a section to inform the provider that juvenile court services and the department shall track the outcome of the service provision following each child's discharge from the service received through the contract.

a. Juvenile court services and the department shall collaborate to determine the criteria and data needed to track and record the outcomes.

b. The provider shall report data as requested by juvenile court services.

c. Juvenile court services shall determine whether the child has reoffended within the 12-month period following the date of discharge from tracking, monitoring and outreach. The service to a child shall be considered successful if the child has not been referred to juvenile court services for a law violation during the 12-month period following the child's discharge from tracking, monitoring and outreach.

d. Data collected on the children served and discharged shall be used to establish or modify a baseline for the provider and for the service. The data shall be used to develop information to make decisions regarding service provision and contracting.

441—151.34(232) Administration of graduated sanction services. The chief juvenile court officer shall purchase graduated sanction services for eligible children pursuant to a contract with juvenile court services and the department.

151.34(1) *Requirements.* Each chief juvenile court officer shall:

a. Establish minimum qualifications for providers of graduated sanction services;

b. Establish criteria and procedures for determining when and where to develop contracts with providers to best meet the service needs of the children in the judicial district; and

c. Require providers to comply with applicable professional standards.

151.34(2) *Referrals.* Each chief juvenile court officer shall develop procedures for eligible children to receive graduated sanction services.

a. Children who are adjudicated delinquent or who are at risk shall apply or be referred for graduated sanction services through the juvenile court services office.

b. School officials may refer adjudicated or at-risk children for school-based supervision services in schools where school-based supervision programs are established.

151.34(3) *Adverse actions.* Graduated sanction services shall be reduced or terminated when:

a. The court orders discontinuation of services; or

b. The juvenile court officer determines that there is no longer a need for service; or

c. The juvenile court officer determines that maximum benefit of service provision has been achieved; or

d. The funds allocated or appropriated for these services are exhausted.

441—151.35(232) Contract development for graduated sanction services. The chief juvenile court officer shall have the responsibility to purchase graduated sanction services (life skills; school-based supervision; supervised community treatment; or tracking, monitoring, and outreach).

151.35(1) *Contracting process.*

a. The chief juvenile court officer for each judicial district shall develop the process for contracting for graduated sanction services. The process shall include:

(1) The rationale for selecting which services to provide;

(2) The provider selection process, including bid solicitations;

(3) Vendor evaluation criteria; and

(4) A procedure for resolving appeals.

b. The chief juvenile court officer shall develop selection criteria for choosing providers to ensure that resources are targeted effectively within the district. Multiple providers may be selected to address the needs within the district.

c. The chief juvenile court officer shall develop a contract with each provider selected through the process.

(1) The chief juvenile court officer or designee shall prepare Form 470-0022, Pre-Contract Questionnaire, for each new contract.

(2) The chief juvenile court officer, the provider, and the department shall sign the contract.

(3) The chief juvenile court officer is responsible for distributing a copy of the signed contract or amendment to the provider.

d. The chief juvenile court officer shall have the authority to resolve provider appeals in accordance with procedures approved by the department.

e. Contract amendments shall be prepared whenever there is a change in the amount of contracted dollars, contract duration, program description, or any other terms of the contract.

(1) Any party to the contract may request an amendment to the contract. The provider may request a contract amendment through the chief juvenile court officer.

(2) The chief juvenile court officer, the provider, and the department shall sign a contract amendment.

(3) The chief juvenile court officer or designee shall prepare Form 470-0022, Pre-Contract Questionnaire, for each contract amendment.

f. The chief juvenile court officer may submit a claim for payment of juvenile court services' costs of printing, copying, distributing and advertising associated with the contracting process. The claim shall be submitted on Form GAX, General Accounting Expenditure. The cost shall be charged first to the administrative set-aside funds and second to the program fund, as funds are available.

151.35(2) *Contract content.* Contracts for purchasing graduated sanction services shall be developed using contract forms approved as to legal form by the assistant attorney general assigned to work with juvenile court services contracts. Contracts with providers shall incorporate all applicable requirements in Iowa Code section 8.47 as well as the administrative and program requirements of this chapter.

a. The contract shall:

(1) Note the unit cost or payment rate;

(2) State the interval for which the cost will be billed;

(3) Describe the process the provider shall follow to complete and submit claims for payment; and

(4) Specify any approved charges for curriculum materials or other expenses that are involved in the delivery of services but not included in the unit cost or payment rate.

b. Contracts with providers of life skills, supervised community treatment, or tracking, monitoring, and outreach services shall establish and define the unit of service and the cost of the unit of service to be provided and billed per child. The contract shall specify the payment amount for the unit

of service and may specify a maximum number of units but shall not ensure a provider reimbursement for a specific rate of utilization. Payment shall be made only for units of service provided to and billed for specific children.

c. Contracts with providers of life skills, supervised community treatment, or tracking, monitoring, and outreach services may establish individual or group rates. The contract shall establish a group rate when the service is provided to more than one child at a time. A minimum and a maximum number of participants shall be established when a group rate is set.

(1) The group rate may be a set amount to be charged for each child who attends the group. The provider will receive payment for each child served.

(2) The group rate may be a set amount to be charged for the group. The provider will receive the same payment amount each time the provider serves the group. The provider must identify all attendees of each group for which payment is claimed.

d. Contracts with providers of supervised community treatment, or tracking, monitoring, and outreach may establish per diem rates when the intensity of service provision per child is variable but the total cost of the provision of the service is known. The range of coverage of the intensity of service provision shall be described in the contract.

These rules are intended to implement Iowa Code section 232.191.

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CHAPTER 152
FOSTER GROUP CARE CONTRACTING

PREAMBLE

This chapter sets forth the contracting process used for providers of foster group care services, including standards for rate-setting, payment mechanisms, and provider monitoring, audits, and sanctions. The term of the contract is limited to no more than six years pursuant to 11—Chapters 106 and 107. The rules also establish provider qualifications, service authorization procedures, documentation requirements, and service termination and appeal procedures associated with foster group care services. Refer to 441—Chapter 156 for additional program requirements.

441—152.1(234) 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.

"Authorized representative," within the context of rule 441—152.9(234), means that person appointed to carry out audit procedures, including an assigned auditor, fiscal consultant, or agent contracted for a specific audit or audit procedure.

"Child" means a person under 18 years of age or a person 18 or 19 years of age who meets the criteria in Iowa Code section 234.1.

"Claim" means each record the department receives that tells the amount of requested payment and the service rendered by a provider to a child and family.

"Client" means a child who has been found to be eligible for foster group care services through the Iowa department of human services.

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

"Contract" means a formal written agreement between the Iowa department of human services and a provider of foster group care services.

"Contract monitor" means a department employee who is assigned to assist in developing, monitoring, and evaluating a contract and to provide related technical assistance.

"Department" means the Iowa department of human services.

"Extrapolation" means that the total dollars of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Family," for purposes of child welfare service delivery, shall include the following:

1. The natural or adoptive parents, stepparents, and children who reside in the same household.
2. A child who lives with an adult related to the child within the fourth degree of consanguinity and the adult relatives within the fourth degree of consanguinity in the child's household who are responsible for the child's supervision. Relatives within the fourth degree of consanguinity include: full or half siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great-nephews, grandparents, great-grandparents, great-great-grandparents, and first cousins.
3. A child who lives alone or who resides with a person or persons not legally responsible for the child's support.

"Fiscal record" means a tangible and legible history that documents the criteria established for financial and statistical records as set forth in subrule 152.2(7).

"Grant" means an award of funds to develop specific programs or achieve specific outcomes.

"Host area" means:

1. The department service area where the provider's corporate office is located, or
2. The service area designated by the chief of the bureau of purchased services when the provider's corporate office is out of state.

"Juvenile court officer" means a person appointed as a juvenile court officer or chief juvenile court officer under Iowa Code chapter 602.

"Level of care" means a type of foster group care service that is differentiated by the ratio of staff to children. There are three levels of foster group care services:

1. Community-level group care (service code D1), which requires a minimum staff-to-client ratio of 1 to 8 during prime programming time.
2. Comprehensive-level group care (service code D2), which requires a minimum staff-to-client ratio of 1 to 5 during prime programming time.
3. Enhanced comprehensive-level group care (service code D3), which requires a minimum staff-to-client ratio during prime programming time as follows:

- 1 staff person for facilities serving up to 4 children.
- 2 staff persons for facilities serving 5 to 7 children.
- 3 staff persons for facilities serving 8 to 10 children.
- 4 staff persons for facilities serving 11 to 13 children.
- 5 staff persons for facilities serving 14 to 16 children.
- 6 staff persons for facilities serving 17 to 19 children.
- 1 staff person for every 3 children for facilities serving 20 or more children.

"Nonprime programming time" means any period of the day other than prime programming time and sleeping time.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to foster group care services and results in a payment greater than that to which the provider is entitled.

"Prime programming time" means any period of the day when special attention, supervision, or treatment is necessary (for example, upon awakening of the clients in the morning until their departure for school, during meals, after school, during transition between activities, evenings and bedtime, and on nonschool days such as weekends, holidays, and school vacations).

"Probation" means a specified period of conditional participation in the provision of foster group care services.

"Provider" means any natural person, company, firm, association, or other legal entity that is seeking a contract or is under contract with the department pursuant to this chapter.

"Random sample" means a systematic (or every "nth" unit) sample for which each item in the universe has an equal probability of being selected.

"Referral worker" means the department worker or juvenile court officer who refers the case to a provider and who is responsible for carrying out the follow-up activities of determining client eligibility and ensuring that the service authorization is completed.

"Service authorization" means the process of determining service necessity and the level of care and number of units of service to be provided to a child.

"Service record" means an individual, tangible, and legible file that records service-related activities set forth in subrule 152.2(6).

"Site" means a location from which services are delivered or where staff report or records are kept. In the foster group care programs, each separately licensed location is a site.

"Sleeping time" means any period of the day during which clients are normally sleeping.

"Suspension of payments" means the withholding of all payments due a provider until resolution of the matter in dispute between the provider and the department.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the foster group care services program and to which the provider is entitled.

"Unit of service" means one day.

"Universe" means all items (claims) submitted by a specific provider for payment during a specific period, from which a random sample will be drawn.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.2(234) Conditions of participation.

152.2(1) *Provider licensure.* The department shall enter into a contract with a provider for foster group care services only when the provider's facility has achieved full licensure as follows:

a. A facility providing community-level group care shall be licensed:

(1) As a community residential facility pursuant to 441—Chapter 114;

(2) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(3) Under comparable standards by the state in which the facility is located.

b. A facility providing comprehensive-level group care shall be licensed:

(1) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(2) Under comparable standards by the state in which the facility is located.

c. A facility providing enhanced comprehensive-level group care shall be licensed:

(1) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(2) Under comparable standards by the state in which the facility is located.

152.2(2) *Provider staffing.* At a minimum, all providers shall meet the requirements for staff qualifications, training, and number of staff pursuant to 441—Chapter 114 or as identified in appendices to Form 470-3052, Foster Group Care Services Contract.

a. All foster group care programs shall provide an appropriate number of hours of prime programming time sufficient to meet the child welfare service needs of the children served in the program.

b. Staffing during prime programming time, nonprime programming time, and sleeping time shall be sufficient to meet the group care maintenance needs of the children served in the program.

152.2(3) *Services provided.* The provider shall comply with the requirements for services to be provided, as described on Form 470-3051, Foster Group Care Services Contract Face Sheet, and appendices to Form 470-3052, Foster Group Care Services Contract. These services shall at a minimum meet the requirements found in 441—Chapter 156 and in 441—Chapter 114 or 441—Chapters 114 and 115, as applicable, or the contract may be terminated.

152.2(4) *Provider charges.* A provider shall not charge departmental clients more than it receives for the same foster group care services provided to nondepartmental clients. The provider shall agree not to require any fee from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy.

152.2(5) *Compliance with the law.* The provider and its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, and orders when performing services under the contract.

a. *Drug-free workplace.* The provider shall operate a drug-free workplace.

b. *Use of funds.* The provider shall:

(1) Agree that federally appropriated funds shall not be paid on behalf of the department or provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with:

1. The awarding of any federal contract,
2. The making of any federal grant,
3. The making of any federal loan,
4. The entering into of any cooperative agreement, or
5. The extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

(2) Ensure that no funds received or expended will be used in any way to promote or oppose unionization.

152.2(6) *Maintenance of service records.* A provider shall maintain complete and legible records as required in this subrule. A provider's client service records and case files for foster group care services shall comply with the requirements of this subrule and with the record-keeping requirements related to licensure pursuant to 441—Chapter 114.

a. The provider shall establish and maintain confidential, individual service records for each client receiving foster group care services. The service records must adequately support the provision of child welfare services and group care maintenance as defined in rule 441—156.1(234). The service record shall include, at a minimum, those items identified in rule 441—114.11(237) and the following:

(1) Additional reports, if requested by the referral worker;

(2) Form 470-3055, Referral and Authorization for Child Welfare Services;

(3) Daily documentation of billed per diem services as defined in paragraph *"b"*; and

(4) Notes indicating the child's general progress in regard to the child's care plan, entered no less than every seven calendar days.

b. Daily documentation of billed per diem services shall include:

(1) The child's first and last name;

(2) The month, day, and year service was provided;

(3) The first and last names of the persons who provided the service;

(4) A clear description of the specific service rendered, including interventions, actions, and activities performed which support the provision of child welfare services; and

(5) Any problem areas or unusual behavior for the child.

c. If individual case files include service records for services other than foster group care services, the provider has the responsibility to maintain the client records in compliance with all applicable rules.

d. The provider shall retain service records for clients receiving foster group care services for a period of not less than five years following the date of final payment or completion of any required audit or review, whichever is later. If any litigation, claim, negotiation, audit, review, or other action involving the records has been started before the expiration of the five-year period, the records must be retained until the later of:

(1) The completion of the action and resolution of all issues which arise from it, or

(2) The end of the regular five-year period.

e. Failure to maintain records or failure to make records available to the department or to its authorized representatives upon request may result in a notice of violation and recoupment of payments, pursuant to rules 441—152.9(234) and 441—152.10(234).

152.2(7) *Maintenance of financial and statistical records.* The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. The records shall be available for review at any time during normal business hours by department personnel, the department's fiscal consultant, and state or federal audit personnel.

a. At a minimum, financial and statistical records shall include all revenue and expenses supported by a provider's general ledger and documentation on file in the provider's office. These records include, but are not limited to:

(1) Payroll information.

(2) Capital asset schedules.

(3) All canceled checks, deposit slips, and invoices (paid and unpaid).

(4) Audit reports (if any).

(5) The board of directors' minutes (if applicable).

(6) Loan agreements and other contracts.

(7) Reviewable, legible census reports and documentation of units of service provided to departmental clients that identify the individual client and are kept on a daily basis and summarized in a monthly report.

(8) For nondepartmental clients, sufficient documentation of utilization to establish a complete unit of service count.

b. The provider shall maintain the following documentation for each program.

(1) A list of all staff and supervisors providing foster group care services and their qualifications.

(2) The number of staff hired and terminated in the year to date.

c. The documentation prepared by the provider shall be retained for use when any financial report is prepared and for review by the department's fiscal consultant. Financial records must be retained for five years from the date of report submission or final payment for services.

d. Independent audits. When a provider has an audit conducted, a firm not related to the provider shall conduct the audit. The provider shall submit a copy of the independent audit report to the department within 30 days of receipt of the report. The bureau of purchased services shall maintain the report and provide a copy of the report to the fiscal consultant.

152.2(8) *Special-purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain client-related or non-client-related activities on behalf of the provider. (For example, a provider may establish a development foundation to assume the provider's fund-raising activity.) Even if the provider does not own the special-purpose organization (e.g., a nonprofit, non-stock-issuing corporation) and has no common governing body membership, a separate special-purpose organization shall be considered a related party for purposes of this chapter when one of the following applies:

a. The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies.

b. For all practical purposes, the provider is the primary beneficiary of the organization's activities. The provider shall be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

(1) The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with the intent of benefiting the provider.

(2) The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider.

(3) The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

152.2(9) *Certification by department of transportation.*

a. If the provider furnishes public transit service as defined in rule 761—910.1(324A), the provider shall annually submit to the contract monitor information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

(1) Form 020107, Certification Application for Coordination of Public Transit Services, which the contract monitor shall submit to the department of transportation; and

(2) A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

b. If a provider believes it does not furnish public transit service as defined in rule 761—910.1(324A) and, therefore, is exempt from the requirements in paragraph *"a,"* the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

c. If a provider that has furnished public transit service as defined in rule 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in paragraph *"a."*

d. If an exempt provider begins to furnish public transit service as defined in rule 761—910.1(324A), the provider shall inform the contract monitor within 30 days of the change and shall adhere to the procedures in paragraph *"a."*

e. Failure of the provider to cooperate in obtaining or providing the required documentation of compliance or exemption is grounds for denial or termination of the contract.

152.2(10) *Copyright and patents.* The activities and results of contract activity may be published subject to confidentiality requirements.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.3(234) Determination of rates. Rates for foster group care services effective on or after November 1, 2006, shall be based on the historical payment rate negotiated between the provider and the department and shall be calculated based on rule 441—156.9(234).

152.3(1) *Negotiation of rates.* Rates for foster group care services effective on or after November 1, 2006, must be established in accordance with this subrule, except as provided in subrule 152.3(4).

a. All historical rate negotiations made under the former rehabilitative treatment and supportive services program on or after February 1, 1998, remain true and valid.

b. The scope of negotiations is limited solely to the rate to be paid for each service.

c. No other items, such as, but not limited to, changes in staff qualifications, service definition, required components, allowable costs or any licensing or other contractual requirements, shall be the subject of negotiations or be used as a basis for changing rates.

d. The service area manager of the host area is responsible for the negotiation of rates for each provider whose contract for foster group care services is administered by the host area, regardless of where the services are provided. Only the service area manager of the host area may approve the rates negotiated for a provider, except as provided in subrule 152.3(4).

(1) The service area manager of the host area shall take into consideration the other service areas served by a provider when negotiating a rate for a service provided in multiple service areas.

(2) When a service is provided only in a nonhost area, the two service area managers shall determine which one will negotiate the rate for that service.

e. The service area manager of the host area and the provider are mutually responsible for initiating the rate negotiation process. Negotiations may be conducted in a manner acceptable to both parties, but shall be conducted face to face upon the request of either party.

f. At the initiation of the rate negotiation process, the provider must disclose all relevant subcontractual and related-party relationships involved in the provision of foster group care services.

g. Negotiated rates shall not exceed any rate ceiling established or authorized by the legislature.

h. Once a negotiated rate is established, it shall not be changed or renegotiated, except in the following circumstances:

(1) Rates may be changed when funds are appropriated for an across-the-board increase. For the fiscal year beginning July 1, 2010, the reimbursement rates for foster group care service providers shall be increased by 1.31 percent over the rates in effect on June 30, 2010.

(2) Rates may be changed by mandated across-the-board decreases.

152.3(2) *New service.* When a prospective provider contracts to provide a foster group care service or an existing provider adds a new foster group care service on or after November 1, 2006, the rate for the new service shall be established based on a payment rate negotiated with the provider.

a. The starting point for negotiated rates shall be the weighted average for each service as of July 1, 1997, as previously established in accordance with 441—subrule 185.109(1), in effect at that time, and further calculated based on rule 441—156.9(234). These rates shall become the established weighted average rates for each service code as described in 441—Chapter 156 and in the appendices of the foster group care contract.

(1) The rate for community-level group care child welfare service is $8.43 per unit of service.

(2) The rate for community-level group care maintenance is $50.16 per unit of service.

(3) The rate for comprehensive-level group care child welfare service is $10.13 per unit of service.

(4) The rate for comprehensive-level group care maintenance is $60.31 per unit of service.

(5) The rate for enhanced comprehensive-level group care child welfare service is $13.36 per unit of service.

(6) The rate for enhanced comprehensive-level group care maintenance is $79.55 per unit of service.

b. In the event the department and a new provider or an existing provider adding a new foster group care service are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, a rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of a rate resolution process, no rate shall be established and the services in question shall not be part of any approved contract for foster group care services.

152.3(3) *Interruptions in a program.*

a. The rate for a new provider shall remain the same as the rate established for the former provider if:

(1) A provider assumes the delivery of a program from a related-party provider, or

(2) The difference between the former provider and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from partnership to corporation).

b. If a provider ceases to contract for and provide a foster group care service on or before October 31, 2006, and before the calculation of new rates according to rule 441—156.9(234), the rate in effect when the contract ceased shall be used to calculate the new rates to be used as the starting point in negotiations.

c. If a provider ceases to contract for and provide a foster group care service after a rate has been established in accordance with rule 441—156.9(234) and then decides to again contract for and provide the foster group care service, the rate shall be established at the rate in effect when the service was interrupted.

152.3(4) *Exception to rate policy.* When a provider not located in Iowa has been granted an exception to these rules based upon another state's requirement that its providers be paid the same rate they are paid for clients from that state, the exception shall continue in effect as written for the life of the contract.

152.3(5) *Across-the-board cuts.* Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8449B**, IAB 1/13/10, effective 1/1/10; **ARC 8652B**, IAB 4/7/10, effective 5/12/10; **ARC 8903B**, IAB 6/30/10, effective 7/1/10]

441—152.4(234) Initiation of contract proposal. All potential providers have a right to request a contract.

152.4(1) *Initial contact.* The initial contact shall be between the potential provider and the bureau of purchased services.

a. At the beginning of the contract development process, the bureau shall give the potential provider:

(1) Information about the contracting process; and

(2) Instructions on how to access the foster group care services provider handbook electronically.

b. The provider shall sign Form 470-3057, Verification of Receipt, at the end of the contract development process to verify receipt of information on how to access the handbook.

152.4(2) *Contract proposal development.* When the bureau of purchased services determines that a new contract is to be developed, a contract monitor shall be assigned to assist in contract development and processing. The contract monitor shall assist the applicant in the completion of the contract proposal and required fiscal information. The contract proposal shall include all of the following:

a. Form 470-3051, Foster Group Care Services Contract Face Sheet.

b. Form 470-3404, Foster Group Care Services Negotiated Rate Establishment Amendment. This form need not be completed until the completion of the rate negotiation process, but the contract proposal will not be acted upon until the form is completed and attached to the contract proposal.

c. Form 470-3052, Foster Group Care Services Contract, or Form 470-3053, Amendment to Foster Group Care Services Contract.

152.4(3) *Contract proposal approval.* The department shall review all complete proposed contracts for compliance with state and federal requirements.

a. The applicant shall submit four copies of the contract proposal to the assigned contract monitor 60 calendar days in advance of the desired effective date of the contract.

b. Submission within the time frame does not ensure the effective date of the contract. The department shall give the applicant notice and explanation in writing of any delay in the approval process.

c. The contract monitor shall forward four signed copies of the contract proposal to the bureau of purchased services within four weeks of receipt.

d. Before the contract can be effective, it shall be approved and signed by the following persons:

(1) An authorized representative of the provider.

(2) The service area manager, who shall make a decision within one week of receipt.

(3) The director of the department or the director's designee, who shall make a decision within 15 days of receipt.

152.4(4) *Rejection of contract proposal.* The department shall give the applicant notice and explanation in writing of the reasons for rejection of the contract proposal within ten working days of the decision. The following criteria may cause a proposed contract or proposed contract amendment to be rejected:

a. The proposed contract does not meet applicable rules, regulations, or guidelines.

b. The applicant has falsified any information required as a condition of participation.

c. Licenses submitted as a condition of participation in the contract process have never been approved or have been revoked or suspended.

d. The provider fails to provide notification within seven days of any changes that may significantly affect the licenses submitted as a condition of contracting.

e. The department and the provider fail to reach agreement on negotiated rates.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.5(234) Contract. All providers shall enter into a contract with the department using Form 470-3052, Foster Group Care Services Contract.

152.5(1) *Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of a new contract, a renewed contract, or an amendment to add a new service code to the contract is the day following signature of the director of the department or the director's designee, unless the provider and the department agree to a later specified date.

a. The contract shall be effective only after the provider is licensed to provide foster group care services as described in subrule 152.2(1).

b. The contract shall be effective only when signed by all parties as required by paragraph 152.4(3)*"d."*

152.5(2) *Liability for payment.* The department shall not be liable for payment for any programs or services before:

a. The contract effective date, or

b. The effective date of the rate for the program or service.

152.5(3) *Term of contract.* Pursuant to the provisions of 11—Chapters 106 and 107, the term of the contract is limited to no more than six years from the effective date of the contract.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.6(234) Client eligibility and referral.

152.6(1) *Determination of eligibility.* The department shall determine a child's eligibility for foster group care services. The department shall not make payment for foster group care services provided before the child's eligibility determination and service authorization.

152.6(2) *Court order.* If a child and family have been referred to the department and the department has not authorized foster group care services, but the services have been ordered by the juvenile court, the department shall make payment subject to availability of authorized funds.

152.6(3) *Service authorization.* Any change in the level of care or increase in the number of units or duration of foster group care services shall be authorized by the department.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.7(234) Billing procedures. At the end of each month, the provider shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided during the month for which the provider has documentation of the billed per diem services as described in subrule 152.2(6). Separate invoices shall be prepared for each county from which clients were referred. Each invoice shall contain claims for only one month of service. A separate invoice is required for each separate month of service if the service spans more than one month.

152.7(1) *Submission of invoices.* Complete invoices shall be sent to the department local office responsible for the client for approval and forwarding for payment. The time limit for submission of

original invoices shall be 90 days from the date of service, except at the end of the state fiscal year when claims for services through June 30 shall be submitted by August 10.

152.7(2) *Resubmittal of rejected claims.* Valid claims that were originally submitted within the time limit specified in subrule 152.7(1) but were rejected because of an error shall be resubmitted as soon as corrections are made.

152.7(3) *Payment.* The invoices shall be subject to audit and adjustment by the department. Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all claims concerning foster group care services rendered to clients.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.8(234) Contract management. During the contract period, the assigned contract monitor designated in the contract shall be the contract liaison between the department and the provider.

152.8(1) The provider shall contact the contract monitor about all interpretations and problems relating to the contract, and the contract monitor shall follow the issues through to their resolution.

152.8(2) The contract monitor shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance if needed. Form 470-0670, Report of On-Site Visit, shall be used to monitor performance under the contract.

152.8(3) The contract monitor shall make at least one on-site visit to each provider during the term of the provider's contract. The on-site visit shall be coordinated with on-site visits scheduled to fulfill requirements for provider reviews, licensing, or other on-site visits required by the department. Site visits to out-of-state providers shall be made at the discretion of the service area responsible for administration of the contract.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.9(234) Provider reviews. The department may review any provider at its discretion at any time. Records generated and maintained by the department or its fiscal agent may be used by reviewers and in all proceedings of the department.

152.9(1) *Review of provider records.* The department shall have the authority to conduct a scheduled or an unannounced site visit to evaluate the adequacy of service records in compliance with the policies and procedures for foster group care services.

152.9(2) *Purpose.* Upon proper identification, authorized representatives of the department shall have the right to review the service and fiscal records of the provider to determine whether:

a. The department has accurately paid claims for services.

b. The provider has furnished the services.

c. The provider has retained service records and fiscal records, as described in subrules 152.2(6) and 152.2(7), that substantiate claims submitted for payment during the review period.

d. Expenses reported to the department have been handled as required under subrule 152.2(8).

152.9(3) *Method.* The department shall select the appropriate method of conducting a review and shall protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Review procedures may include, but are not limited to, the following:

a. Comparing service and fiscal records with each claim.

b. Interviewing clients and employees of providers.

152.9(4) *Sampling.* The department's procedures for reviewing a provider's service records may include the use of random sampling and extrapolation. When these procedures are used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level.

a. *Findings.* The review findings generated through the review procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. *Extrapolation.* Findings of the sample will be extrapolated to the universe for the review period. The total of the payments determined to be in error in the review sample shall be divided by the total payments in the reviewed sample to calculate the percentage of dollars paid in error. This percentage

shall then be multiplied by the total payments in the review universe to determine the extrapolated overpayment.

c. *Disagreement with findings.* When the provider disagrees with the department's review findings and the findings have been generated through sampling and extrapolation, the provider may present evidence to show that the sample was invalid. The burden of proof of compliance rests with the provider. The evidence may include a 100 percent review of the universe of provider records used by the department in the drawing of the department's sample. This review shall:

(1) Be arranged and paid for by the provider.

(2) Be conducted by a certified public accountant.

(3) Demonstrate that bills and records not reviewed in the department's sample complied with program regulations and requirements.

(4) Be submitted to the department with all supporting documentation.

152.9(5) *Actions based on review findings.*

a. The department shall report the results of a review of provider records to concerned parties consistent with the provisions of 441—Chapter 9.

b. When an overpayment is found, the department may do one or more of the following:

(1) Request repayment in writing.

(2) Impose sanctions provided for in rule 441—152.10(234).

(3) Investigate and refer the matter to an agency empowered to prosecute.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.10(234) Sanctions against providers. Failure to meet the requirements relevant to provider contracting, financial record keeping, billing and payment, and client record keeping may subject providers to sanctions.

152.10(1) *Grounds for sanction.* The department may impose sanctions against a provider for committing one or more of the following actions:

a. Failing to provide and maintain the quality of the services to children and families within established standards, including:

(1) Failing to meet standards required by state or federal law for licensure.

(2) Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

(3) Engaging in a course of conduct or performing an act that is in violation of state or federal regulations or continuing that conduct following notification that it should cease.

(4) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions subject to this chapter.

(5) Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

(6) Being suspended or terminated from participation in another governmental program such as, but not limited to, workers' compensation or Medicaid remedial services.

(7) Committing a negligent practice resulting in client death or injury.

b. Failing to disclose or make available to the department or its authorized agent records of services provided to a child and family and records of payments made for those services.

c. Engaging in deceptive billing practices, such as:

(1) Presenting or causing to be presented for payment any false or deceptive claim for services.

(2) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

d. Submitting or causing to be submitted false information to meet service authorization requirements.

e. Inducing, furnishing or otherwise causing the child or family to receive foster group care services that are not authorized (overutilization of services).

f. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

g. Failing to repay or arrange for the repayment of identified overpayments or other erroneous payments.

152.10(2) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or 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.

a. Notification shall set forth:

(1) The nature of the discrepancies or violations.

(2) The known dollar value of the discrepancies or violations.

(3) The method of computing the dollar value.

(4) Further actions to be taken or sanctions to be imposed by the department.

(5) Any actions required of the provider.

b. The provider shall have 15 days after the date of the notice and before the department action to show cause why the action should not be taken.

152.10(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 152.10(1):

a. A term of probation for provision of foster group care services.

b. Termination from participation in the provision of foster group care services.

c. Suspension from provision of foster group care services.

d. Suspension or withholding of payments to the provider.

e. Review of 100 percent of the provider's claims before payment.

f. Referral to the appropriate state licensing board for investigation.

g. Referral of the matter to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of foster group care services licensure.

i. Termination of foster group care services licensure.

152.10(4) *Imposition and extent of sanction.* The department shall determine what sanction to impose. The following factors shall be considered in determining the sanction or sanctions to be imposed:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of technical assistance.

f. Pattern of failure to follow program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing bodies.

152.10(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider. Each decision to include an affiliate shall be made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated when the conduct was committed in the course of official duty or was effectuated with the knowledge or approval of that person.

b. When there are grounds for sanction pursuant to subrule 152.10(1) against a provider facility, campus, or site, the department may suspend or terminate the provision of foster group care services by:

(1) The provider; or

(2) The specific facility, campus, or site; or

(3) Any individual within the provider's organization who is responsible for the violation.

c. No provider shall submit claims for payments to the department for any services provided by any facility, campus, site, or person within the organization that has been suspended or terminated from provision of foster group care services except for those services provided before the suspension or termination.

d. Suspension or termination from provision of foster group care services shall preclude the submission of claims to the department for payment for any services provided after suspension or termination, whether submitted personally or through the provider.

152.10(6) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to paragraph 152.9(5)*"b"* or subrule 152.10(2) and has demanded repayment of an identified 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. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

152.10(7) *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.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.11(234) Appeals of departmental actions. Providers may appeal decisions of the department, other than rate determinations, according to rules in 441—Chapter 7.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

These rules are intended to implement Iowa Code section 234.6.

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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:

a. 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.

b. Generate a delivery receipt for the application, whether sent to the division by E-mail, fax, or certified mail. The division may require the delivery receipt when it is alleged that an application was sent but the division has no record of receiving the application.

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; **ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8611B**, IAB 3/10/10, effective 4/14/10; **ARC 8612B**, IAB 3/10/10, effective 4/14/10]

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 application date as defined in subrule 153.53(4).

b. Each member shall be assigned a payment slot number based on the member's application date and commitment status.

(1) Members under a court-ordered involuntary commitment shall be considered the first priority for payment slot number assignment, in order of oldest commitment date first. The CPC shall notify the department within seven days of the date when the commitment order is released. When the commitment order is released, the member shall be reassigned a payment slot according to subparagraph 153.54(5)*"b"*(2).

(2) Slot number assignment for members who are not under an involuntary commitment order shall be based on the application date. For a member who was on a commitment order which has been released, the application date is the date of the member's first commitment order or the member's original application date, whichever is earliest. If there are multiple members with the same application date, the members will be prioritized by the birth month and day (earliest birth date first). If there are multiple members with the same birth month and day, the last four digits of the members' social security numbers will be used, with the lowest number being considered first.

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.* The department shall start a waiting list when analysis of submitted expenditure reports indicates that the amount of funds needed to pay for the currently assigned payment slots exceeds the state payment program appropriation.

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 exception of applicants who are subject to an involuntary commitment. Applicants who are subject to an involuntary commitment are exempted from waiting list placement for the services listed on the court order when the CPC includes a copy of relevant court orders directing

services under Iowa Code chapter 229 for which payment is sought. If this documentation is not included, the application will be placed on the waiting list.

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 of 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; **ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8611B**, IAB 3/10/10, effective 4/14/10; **ARC 8612B**, IAB 3/10/10, effective 4/14/10]

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.

c. Scheduled appointments or consultations for which the member did not appear.

d. Service management (county chart of accounts numbers beginning with 22-000) for members eligible for Medicaid targeted case management, unless the Iowa plan contractor decertifies the member for case management services.

e. Services described by the following county chart of accounts codes:

(1) 4x03, information and referral.

(2) 4x04, consultation.

(3) 4x11, direct administrative.

(4) 4x12, purchased administrative.

(5) 4x21-374, case management Medicaid match.

(6) 4x32-328, home/vehicle modification.

[**ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8612B**, IAB 3/10/10, effective 4/14/10]

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 six-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.

[**ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8612B**, IAB 3/10/10, effective 4/14/10]

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.

153.57(1) *Termination of eligibility.* A member shall remain eligible until:

a. Reimbursement for episodic commitment costs has been made to the county if the member was enrolled for commitment costs only;

b. The CPC in the county of residence notifies the state payment program manager that the member is no longer eligible;

c. No services have been reported for the member for six months; or

d. The member is disenrolled pursuant to subrule 153.57(2).

153.57(2) *Disenrollment.* If instituting a waiting list does not adequately address the funding shortfall, the department shall begin disenrollment of members.

a. Members who are enrolled and receiving services being reimbursed by the state and who are not under court-ordered involuntary commitment shall be disenrolled beginning with the highest payment slot number first.

b. The department shall notify the member and the CPC when a member is to be disenrolled. The department shall give the member at least ten days' notice of disenrollment pursuant to rule 441—7.7(17A). The department shall give a member receiving any residential service 30 days' notice of disenrollment from the program consistent with department of inspections and appeals' rule 481—57.36(135C).

c. Any member who is disenrolled shall be placed on the waiting list as provided in subrule 153.54(5).

[**ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8612B**, IAB 3/10/10, effective 4/14/10]

441—153.58(331) Appeals.

153.58(1) Decisions regarding denial or termination of state payment program eligibility, including disenrollment, may be appealed to the department pursuant to 441—Chapter 7. Continuation of assistance will be granted pursuant to rule 441—7.9(17A).

153.58(2) Decisions (other than eligibility) adversely affecting applicants or members shall be appealed pursuant to the county CPC's appeal provisions.

[**ARC 8319B**, IAB 12/2/09, effective 11/1/09; **ARC 8486B**, IAB 1/13/10, effective 1/1/10; **ARC 8611B**, IAB 3/10/10, effective 4/14/10]

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CHAPTER 154

Rescinded IAB 9/6/89, effective 11/1/89

[See 441—Chapter 168]

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

[Prior to 7/1/83, Social Services[770] Ch 146]
[Previously appeared as Ch 146—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define and structure the child abuse prevention program. Services are provided through a single statewide performance-based contract for the administration of funds to be used at the local level for community-based child abuse prevention projects.

441—155.1(235A) Definitions.

"Advisory committee" or *"committee"* means the child abuse prevention program advisory committee authorized by Iowa Code section 217.3A.

"Child abuse prevention program" or *"program"* means the program established by Iowa Code section 235A.1. Use of either term in the context of this chapter refers to the program as a whole rather than individual projects funded under the program.

"Community-based volunteer coalition or council" or *"community council"* means that group of persons who, by consensus of a community's human service providers, represent that community's interests in the area of prevention of child abuse and neglect and who serve in that representational capacity without compensation. The consensus of the community's human service providers may be demonstrated through letters of support or similar documentation.

"Contractor" means the single agency or organization with which the department contracts for the administration of child abuse prevention program funds.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services.

"Fiscal year" means the 12-month period for which child abuse prevention program funds are appropriated.

"Grant project" means a project funded under the child abuse prevention program as awarded by the contractor.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11]

441—155.2(235A) Contract for program administration. The department shall contract for the administration of the child abuse prevention program through formal competitive procurement conducted according to the requirements of 11—Chapters 106 and 107.

155.2(1) *Eligibility requirements.* Eligibility for the program administration contract is limited to statewide agencies or organizations that make maximum use of voluntary administrative services.

155.2(2) *Duties.* The department shall contract with a single agency or organization to:

a. Administer the appropriated funds and any grants, gifts or bequests to the department that are specifically designated by their source for use in the child abuse prevention program; and

b. Study and evaluate community-based prevention projects and educational programs for the problems of families and children in accordance with the provisions of Iowa Code section 235A.1 and this chapter.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11]

441—155.3(235A) Awarding of grants. In any year in which funding is appropriated or otherwise made available for the child abuse prevention program, the contractor shall solicit grant project proposals. Funds for the grant projects shall be applied for and received by community-based volunteer coalitions or councils. Grant projects may be awarded to fund the establishment or expansion of community-based prevention projects or educational programs for the prevention of child abuse and neglect.

155.3(1) The advisory committee shall establish specific program goals for each fiscal year in which program funds are appropriated. These program goals shall address the current and emerging needs of children and families throughout the state.

155.3(2) The contractor shall widely disseminate a request for grant project proposals consistent with all state and federal procurement requirements. The request for grant project proposals shall fully describe the child abuse prevention program goals and the procedures for applying for and receiving program funds, as agreed upon in the administration contract.

155.3(3) All grant project proposals shall be reviewed by the contractor, who shall consult with the advisory committee on grant project selection. The committee shall advise the department as to the contractor's compliance with the established program goals.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11]

These rules are intended to implement Iowa Code sections 235A.1 and 235A.2.

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CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

"Department" means the Iowa department of human services.

"Director" means the director of the child support recovery unit of the department or the director's designee.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Mental retardation professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the

educational requirements for the profession, as required in the state of Iowa, and has one year of experience working with persons with mental retardation.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Service area manager" means the department employee or designee responsible for managing department offices within a department service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care which require additional skill, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

"Unearned income" means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$16.78
6 through 11	$17.45
12 through 15	$19.10
16 or over	$19.35

156.6(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.6(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.6(4) *Difficulty of care payment.*

a. For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus $5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

b. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

c. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

d. Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

e. Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, mental health professional, or mental retardation professional, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

f. For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.44 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

156.6(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.6(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38 and 2013 Iowa Acts, Senate File 446, sections 18 and 19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8904B**, IAB 6/30/10, effective 7/1/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0240C**, IAB 8/8/12, effective 7/11/12; **ARC 0419C**, IAB 10/31/12, effective 12/5/12; **ARC 0858C**, IAB 7/24/13, effective 7/1/13; **ARC 1061C**, IAB 10/2/13, effective 11/6/13]

441—156.7(234) Purchase of family foster care services. Rescinded IAB 5/6/09, effective 7/1/09.

441—156.8(234) Additional payments.

156.8(1) *Clothing allowance.* When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed $237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed $190 for family foster care and $100 for all other levels when:

(1) The child needs clothing to replace lost clothing or because of growth or weight change, and

(2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.8(2) *Supervised apartment living.* Effective July 1, 2013, when a child is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $630 if the child does not have sufficient resources to cover initial costs.

156.8(3) *Medical care.* When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

156.8(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the

expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.8(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.8(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed $5 may be authorized by the department worker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or a mental retardation professional has recommended school attendance.

156.8(7) *Respite care.* The service area manager or designee may authorize respite for a child in family foster care for up to 24 days per calendar year per placement. Respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0856C**, IAB 7/24/13, effective 7/1/13; **ARC 1062C**, IAB 10/2/13, effective 11/6/13]

441—156.9(234) Rate of payment for foster group care.

156.9(1) *In-state reimbursement.* Effective November 1, 2006, public and private foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with the rate-setting methodology in this subrule.

a. A provider of group care services shall maintain at least the minimum staff-to-child ratio during prime programming time as established in the contract. Staff shall meet minimum qualifications as established in 441—Chapters 114 and 115. The actual number and qualifications of the staff will vary depending on the needs of the children.

b. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

c. Reimbursement rates shall be adjusted based on the provider's rate in effect on October 31, 2006, to reflect an estimate that group care providers will provide an average of one hour per day of group remedial services and one hour per week of individual remedial services. The reimbursement rate shall be calculated as follows:

(1) Step 1. Annualize the provider's combined daily reimbursement rate for maintenance and service in effect on October 31, 2006, by multiplying that combined rate by 365 days.

(2) Step 2. Annualize the provider's remedial services reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

(3) Step 3. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

(4) Step 4. Add the amounts determined in Steps 2 and 3.

(5) Step 5. Subtract the amount determined in Step 4 from the amount determined in Step 1.

(6) Step 6. Divide the amount determined in Step 5 by 365 to compute the new combined maintenance and child welfare service per diem rate.

(7) Step 7. Determine the maintenance portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 85.62 percent.

(8) Step 8. Determine the child welfare service portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 14.38 percent.

EXAMPLE: Provider A has the following rates as of October 31, 2006:

- A combined daily maintenance and service rate of $121.45;
- A Medicaid rate for service code 96153 of $5.10 per 15 minutes, or $20.40 per hour;
- A Medicaid rate for service code 96152 of $19.92 per 15 minutes, or $79.68 per hour.

Step 1. $121.45 × 365 days = $44,329.25

Step 2. $20.40 × 365 days = $7,446.00

Step 3. $79.68 × 52 weeks = $4,143.36

Step 4. $7,446.00 + $4,143.36 = $11,589.36

Step 5. $44,329.25 - $11,589.36 = $32,739.89

Step 6. $32,739.89 ÷ 365 days = $89.70

Step 7. $89.70 × 0.8562 = $76.80 maintenance rate

Step 8. $89.70 × 0.1438 = $12.90 child welfare service rate

Provider A's rates are $76.80 for maintenance and $12.90 for child welfare services.

d. No less than annually, the department shall redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions based on review of verified remedial services cost reports for foster group care services providers. If the new allocation differs from the current allocation, the department shall:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates and the effective date.

156.9(2) *Out-of-state group care payment rate.* The payment rate for maintenance and child welfare services provided by public or private agency group care licensed or approved in another state shall be established using the same rate-setting methodology as that in subrule 156.9(1), unless the director determines that appropriate care is not available within the state pursuant to the following criteria and procedures.

a. *Criteria.* When determining whether appropriate care is available within the state, the director shall consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service fund or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. *Procedure.* The service area manager or chief juvenile court officer shall submit the request for director's exception to the Appeals Section, Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in 156.9(2)*"a."*

c. *Appeals.* The decision of the director regarding approval of an exception to the rate determination in rule 441—152.3(234) is not appealable.

156.9(3) *Supplemental payments for in-state facilities.* Rescinded IAB 9/1/93, effective 8/12/93.

156.9(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, the maintenance rate for the mother shall include an additional amount to cover the actual and allowable maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

a. The rate shall be determined according to the policies in rule 441—152.3(234) and added to the maintenance rate for the mother. The young child portion of the maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

b. Rescinded IAB 6/8/94, effective 6/1/94.

c. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

d. The facility shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or general education equivalent (GED).

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

e. The agency shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a GED program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

f. The agency shall designate $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8715B**, IAB 5/5/10, effective 7/1/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11]

441—156.10(234) Payment for reserve bed days.

156.10(1) *Group care facilities.* The department shall provide payment for group care maintenance and child welfare services according to the following policies.

a. *Family visits.* Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the worker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility shall be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. *Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. *Runaways.* Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.

(3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. *Preplacement visits.* Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.10(2) *Foster family care.*

a. *Family visits.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

b. *Hospitalization.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. *Runaways.* Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home shall be for the child to return to the foster family home.

(3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(4) Payment shall not exceed two consecutive days.

156.10(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.11(234) Emergency care.

156.11(1) and **156.11(2)** Rescinded IAB 3/11/09, effective 5/1/09.

156.11(3) Shelter care payment. Public and private juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the rate-setting methodology in 441—paragraph 150.3(5)*"p."*

a. Facilities shall bill for actual units of service provided in accordance with 441—subrule 150.3(8). In addition, facilities may be guaranteed a minimum level of payment to the extent determined by the department through a request-for-proposal process.

(1) Guaranteed payment shall be calculated monthly.

(2) The guaranteed level of payment shall be calculated by multiplying the number of beds for which payment is guaranteed by the number of days in the month.

(3) When the actual unit billings for a facility do not equal the guaranteed level of payment for the month, the facility may submit a supplemental billing for the deficiency.

(4) The amount of the supplemental billing shall be determined by multiplying the facility's unit cost for shelter care by the number of units below the guaranteed level for the month for which the facility was not reimbursed.

b. The total reimbursement to the agency shall not exceed the agency's allowable costs as defined in 441—subrule 150.3(5). Agencies shall refund any payments which have been made in excess of the agencies' allowable costs.

c. Shelter contracts for the state fiscal year beginning July 1, 2007, shall provide for the statewide availability of a daily average of 273 guaranteed emergency juvenile shelter care beds during the fiscal year.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09]

441—156.12(234) Supervised apartment living.

156.12(1) *Maintenance.* Effective July 1, 2013, when a child at least aged 16½ but under the age of 20 is living in a supervised apartment living situation, the monthly maintenance payment for the child shall be $787.50. This payment may be paid to the child or another payee, other than a department employee, for the child's living expenses.

156.12(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35 and 2011 Iowa Acts, House File 649, section 28(4).

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0856C**, IAB 7/24/13, effective 7/1/13; **ARC 1062C**, IAB 10/2/13, effective 11/6/13]

441—156.13(234) Excessive rates. Rescinded IAB 6/9/93, effective 8/1/93.

441—156.14(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

441—156.15(234) Child's earnings. Earned income of a child who is not in a supervised apartment living arrangement and who is a full-time student or engaged in an educational or training program shall be reported to the department and its use shall be a part of a plan for service, but the income shall not be used towards the cost of the child's care as established by the department. When the earned income of children in supervised apartment living arrangements or of other children exceeds the foster care standard, the income in excess of the standard shall be applied to meet the cost of the child's care. When the income of the child exceeds twice the cost of maintenance, the child shall be discontinued from foster care.

441—156.16(234) Trust funds and investments.

156.16(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

156.16(2) The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

156.16(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.17(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.18(237) Foster parent training expenses. Rescinded IAB 7/29/09, effective 10/1/09.

441—156.19(237) Rate of payment for care in a residential care facility. When a child is receiving group care maintenance and child welfare services in a licensed residential care facility and is not eligible for supplemental security income or state supplementary assistance, the department will pay for the group care maintenance and child welfare services in accordance with subrule 156.9(1). When a child receives group care maintenance and child welfare services in a licensed residential care facility and is eligible for supplemental security income or state supplementary assistance, the department will pay for child welfare services in accordance with subrule 156.9(1).

This rule is intended to implement Iowa Code section 237.1(3)*"e."*

441—156.20(234) Eligibility for foster care payment.

156.20(1) *Client eligibility.* Foster care payment shall be limited to the following populations.

a. Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52, subsection 2, paragraph *"d,"* Iowa Code section 232.102, subsection 1, Iowa Code section 232.117, or Iowa Code section 232.182, subsection 5.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20, subsection 1, or Iowa Code section 232.21.

3. The department has agreed to provide foster care pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements which have been authorized by the department and which conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria. The child's eligibility for the exception shall be documented in the case record.

1. The child does not have mental retardation. Funding for services for persons with mental retardation is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds which may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area's funding allocation shall be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in subrule 156.6(4), paragraph *"a,"* and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.20(2) *Provider eligibility for payment.*

a. Providers of shelter care services and supervised apartment living services shall have a purchase of service contract under 441—Chapter 150 in force.

b. Providers of group care services shall have a foster group care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

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CHAPTER 157
PURCHASE OF ADOPTION SERVICES

[Prior to 2/11/87, Human Services [498]]

Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 158
FOSTER HOME INSURANCE FUND

PREAMBLE

These rules implement the provisions of the foster home insurance fund. These rules define eligible claims, the payment limits for claims, the procedure for filing claims, and the time frames for filing claims.

441—158.1(237) Payments from the foster home insurance fund.

158.1(1) *Eligible foster family claims.* The foster home insurance fund shall pay the following within the limits defined in Iowa Code section 237.13, subsections 3 and 4:

a. Valid and approved claims of family foster care children, their parents, guardians or guardians ad litem.

b. Compensation to licensed foster families for property damage, at replacement cost, or for bodily injury, as a result of the activities of the family foster care child.

c. Reasonable and necessary legal fees incurred by licensed foster families in defense of civil claims filed pursuant to Iowa Code section 237.13, subsection 7, paragraph *"d,"* and any judgments awarded as a result of these claims. The reasonableness and necessity of legal fees shall be determined by the department or its contract agent.

158.1(2) *Eligible guardian and conservator claims.* Rescinded IAB 10/5/11, effective 11/9/11.

[**ARC 9779B**, IAB 10/5/11, effective 11/9/11]

441—158.2(237) Payment limits. The fund is not liable for the first $100 for all claims arising out of one or more occurrences during a fiscal year related to a single foster home. The fund is not liable for damages in excess of $300,000 for all claims arising out of one or more occurrences during a fiscal year related to a single home.

[**ARC 9779B**, IAB 10/5/11, effective 11/9/11]

441—158.3(237) Claim procedures. Claims against the fund shall be filed with the department's contractor. If the department does not have a contractor, claims shall be filed on Form 470-2470, Foster Home Insurance Fund Claim. The decision to approve or deny the claim shall be made by the department or its contractor and the notice mailed or given to the claimant within 180 days of the date the claim is received.

441—158.4(237) Time frames for filing claims.

158.4(1) Claims by children who were under the age of 18 at the time of the occurrence shall be submitted within two years of the date of the occurrence or after the child's eighteenth birthday, but before the child's nineteenth birthday.

158.4(2) Claims by persons who were aged 18 or older at the time of the occurrence shall be submitted within two years of the occurrence.

158.4(3) Claims by foster parents pursuant to paragraph 158.1(1)*"c"* for legal fees or court-ordered judgments shall be submitted within two years of the date of the judgment.

[**ARC 9779B**, IAB 10/5/11, effective 11/9/11]

441—158.5(237) Appeals. Claimants dissatisfied with the decision may request a fair hearing under the provisions of 441—Chapter 7.

These rules are intended to implement Iowa Code section 237.13 as amended by 2011 Iowa Acts, Senate File 482, division II.

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CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL SERVICES

PREAMBLE

These rules define the process for awarding grants for the delivery of child care resource and referral services.

441—159.1(237A) Definitions.

"Applicant" means an agency that applies for a contract as a regional child care resource and referral agency.

"Child care facility" means a child care center, preschool, or child development home.

"Child care resource and referral agency" means a community-based nonprofit incorporated agency or public agency that is under a contract with the department to provide resource and referral services as defined in subrule 159.3(1).

"Director" means the director of the department of human services.

"Region" means the service area of the child care resource and referral agency as determined in the contract with the department.

[**ARC 8654B**, IAB 4/7/10, effective 6/1/10]

441—159.2(237A) Availability of funds. In any year in which funds are available for child care resource and referral services, the department shall award grants for child care resource and referral services pursuant to a request for proposals.

159.2(1) The total amount of grant moneys awarded shall be contingent upon the funds available.

159.2(2) Grants shall be issued on a regional basis. The department shall determine the amount of grant money available for each region based upon the factors set forth in the request for proposals.

[**ARC 8654B**, IAB 4/7/10, effective 6/1/10]

441—159.3(237A) Participation requirements.

159.3(1) *Resource and referral services.* Grants will be awarded to community-based nonprofit incorporated agencies and public agencies that have the capacity to provide all of the following types of services:

a. *Parent services.*

(1) The agency shall assist families in selecting quality child care and shall provide referrals to child care facilities.

(2) The agency may provide referrals to child care homes and may provide specialized referral services to employers.

b. *Provider services.* The agency shall:

(1) Assist child care providers in adopting developmentally appropriate programs and sustainable business practices to provide quality child care services through the delivery of consultation, training, and other resources and materials.

(2) Support the development of new child care facilities and the expansion of existing child care facilities in response to identified needs.

(3) Encourage participation of eligible child care facilities in the federal Child and Adult Care Food Program (CACFP).

c. *Community services.* The agency shall:

(1) Provide information to the public regarding the availability and quality of child care services within the agency's region.

(2) Coordinate with other public and private entities and services within the region. Activities shall include coordinating with community-level efforts to improve the consistency and quality of data collection, consultation and other supports to child care homes and child development homes, particularly the efforts of home consultants funded by a community empowerment area board.

d. *Other.* The agency shall offer such other services as set forth in the request for proposals issued by the department.

159.3(2) *Matching funds.* The agency must provide a financial match of the grant award as set forth in the request for proposals. Eligible match includes in-kind contributions, private donations and public funding.
[**ARC 8654B**, IAB 4/7/10, effective 6/1/10]

441—159.4(237A) Request for proposals for project grants. The department shall announce the request for proposals through public notice.

159.4(1) *Proposal submittal.* All applicants shall submit proposals to Iowa Department of Human Services, Bureau of Child Care, Hoover State Office Building, Fifth Floor, 1305 E. Walnut, Des Moines, Iowa 50319-0114.

159.4(2) *Proposal requirements.* To be eligible for review, a proposal shall:

a. Be received by the due date specified in the request for proposals;

b. Be in the form prescribed by the department in the request for proposals; and

c. Meet the requirements set forth in the request for proposals.
[**ARC 8654B**, IAB 4/7/10, effective 6/1/10]

441—159.5(237A) Selection of proposals. The selection criteria for the grants shall be set forth in the request for proposals.

159.5(1) The director shall make the final decision regarding grants awarded to applicants. Only one grant shall be awarded in each specified region to the agency that best meets the criteria set forth in the request for proposals.

159.5(2) The department reserves the right to award grants for less than the amount of appropriated funds if there is an insufficient number of acceptable proposals submitted to adequately achieve the purpose of child care resource and referral services statewide.
[**ARC 8654B**, IAB 4/7/10, effective 6/1/10]

These rules are intended to implement Iowa Code section 237A.26.

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CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM

PREAMBLE

These rules define and structure the adoption opportunity grant program. The services under the grant program are to be provided to special needs children, prospective adoptive families and adoptive families in an effort to place children in adoptive families and to prevent disruptions and dissolutions.

441—160.1(234) Definitions.

"Adoptive family" means an approved family who has a special needs child placed in their family for the purpose of adopting the child, or a family with a special needs child in their family whose adoption has been finalized by the court.

"Applicant" means a private agency licensed in Iowa as a child-placing agency that offers a continuum of child welfare services to families and special needs children, or an individual provider involved in providing services to adoptive families and special needs children which makes application for a grant.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services.

"Grant review committee" means a five-member committee composed of two departmental employees and two private child-placing agency employees or supervisors who work with children and adoptive families, but are not currently applying for a grant, and one member with a fiscal background, responsible for reviewing and designating grant awards.

"Grantee" means an applicant who has been awarded a grant.

"Prospective adoptive family" means a family with an approved home study waiting placement of a special needs child into their family for the purpose of adoption.

"Special needs child" means a child as defined in 441—subrule 201.3(1).

441—160.2(234) Availability of grant funds. The amount of money granted shall be contingent upon the amount of federal grant funds available to Iowa in a given year. The allocation of funds shall be in compliance with legislation and approved by the grant review committee.

441—160.3(234) Project eligibility.

160.3(1) *Grant awards.* Grants will be awarded to eligible applicants for specifically designed adoption projects with the duration of the projects based on the time frames specified in the relevant federal grant.

160.3(2) *Residence of clients.* A grantee may not use grant funds to serve residents of states other than Iowa.

160.3(3) *Services.* Grants will be awarded to provide one or more of the following services:

a. Preplacement assessment and adoptive home studies of families wishing to adopt a special needs child.

b. Training and preparation of families for adoption.

c. Preparation of children for adoption.

d. Postplacement services.

e. Postadoption services.

f. Other specified services as stated in the federal grant award to Iowa.

441—160.4(234) Request for proposals for project grants.

160.4(1) *Application.* The department will announce through a request for proposals the opening of an application period. The request shall state the purpose for which grant funds shall be spent. A grant application shall be included in the request for proposals. Applicants shall submit their grant proposal

using Form 470-2910, Application for Adoption Opportunity Grant Funding, by the deadline specified in the announcement.

160.4(2) *Project proposal requirements.* Requirements for project proposals shall be specified in the "Adoption Opportunity Grant Application Packet." If a proposal does not contain the information specified in the application packet, or if it is late, it will be disapproved. Proposals accepted for review shall contain the following information:

a. Application for Adoption Opportunity Grant Funding, Form 470-2910.
b. Proposal summary.
c. Reason for grant request, including statement of problems and needs.
d. Agency background information and demonstrated effectiveness.
e. Project goals, objectives and methods.
f. Project monitoring and evaluation.
g. Project budget and budget forms.
h. Plans for future funding.
i. Assurances and certification.
j. Letters of support.
k. Explanation of grantee share of matching funds, when applicable.
l. Project checklist.

Projects will demonstrate that they can be replicated for use with families and special needs children in other parts of the state.

Projects will be coordinated with other local agencies or groups.

441—160.5(234) Selection of proposals.

160.5(1) *Evaluation of proposals.* All proposals completed as directed and submitted within the time frames allowed will be evaluated by the grant review committee to determine which applicants will be awarded grants.

160.5(2) *Factors in selection.* The following factors will be considered in selecting proposals for grant awards:

a. The demonstrated need for the service in the program area selected and assurance that the proposed project does not duplicate other services offered in the community.

b. The support of and coordination with other existing agencies providing services to the targeted population.

c. The program structure, including how realistic goals and objectives are, likelihood of the anticipated impact on the problem addressed, experience serving similar populations or providing similar services, administration of funds, stability of the organization and the overall quality of the proposal in comparison to other proposals submitted.

d. Plans for use of funds. Grant funds may not be used for construction, capital improvements, or purchase of real estate.

e. Potential of replicating the project in other parts of the state.

160.5(3) *Scoring criteria.* A weighted criteria will be used to determine grant awards. A maximum of 110 points is possible. Determination of final point awards will be based on the following:

a. Proposal summary—10 points.
b. Statement of problems and need—20 points.
c. Agency background information and demonstrated effectiveness—15 points.
d. Project goals, objectives and methods of attainment—25 points.
e. Project monitoring and evaluation—10 points.
f. Budget information points—15 points.
g. Future funding and applicant assurances and certification—5 points.
h. Overall quality and impact of program—10 points.

441—160.6(234) Project contracts. The funds for approved applicants will be awarded through a contract entered into by the director and the applicant. The contract period shall not exceed the time

frames of the federal grant awarded to the department. Expenditures shall be reimbursed monthly pursuant to the regular reimbursement procedures of the state of Iowa.

441—160.7(234) Records. Grantees shall keep client and fiscal records of services provided and any other records required by the department and specified in the contract.

441—160.8(234) Evaluation of projects. The department or a designee shall evaluate the grantee at least once prior to the end of the contract period to determine whether or not the goals are being met and shall provide feedback to the grantee. Funding is to be spent to meet the program goals stated in the contract. Grantees may request and receive copies of the department's evaluation of their grant project.

441—160.9(234) Termination. The contract may be terminated by either party at any time during the contract period by giving 30 days' notice to the other party.

160.9(1) *Notice of termination.* The department may terminate a contract upon 10 days' notice when a grantee fails to comply with the award stipulation, standards or conditions.

160.9(2) *Financial statement.* Within 45 days of termination of a contract, the grantee shall supply the department with a financial statement detailing all costs up to the effective date of the termination.

160.9(3) *Availability of funding.* The department shall administer the funds for the adoption grants contingent upon their availability. If the department lacks the funding necessary to fulfill its fiscal responsibility under the adoption grant program, the contracts shall be terminated or renegotiated.

441—160.10(234) Appeals. Applicants dissatisfied with the grant review committee's decision may file an appeal with the director. The written appeal must be received within ten working days of the date of the notice of decision; must be based on a contention that the process was conducted outside of statutory authority, violated state or federal law, policy or rules, did not provide adequate public notice, was altered without adequate public notice, or involved conflict of interest by staff or committee members; and must include a request for the director to review the decision and the reasons for dissatisfaction. Within ten working days of receipt of the appeal the director will review the appeal request and issue a final decision. No disbursements will be made to any applicant for a period of ten calendar days following the notice of decision. If an appeal is filed within ten days, all disbursements will be held pending a final decision on the appeal. All applicants involved will be notified if an appeal is filed and given the opportunity to be included as a party in the appeal.

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 161
IOWA SENIOR LIVING TRUST FUND

PREAMBLE

These rules describe the Iowa senior living trust fund created by 2000 Iowa Acts, Senate File 2193, and explain how public nursing facilities can participate in a program for funding of the senior living trust fund.

441—161.1(249H) Definitions.

"Department" means the Iowa department of human services.

"Senior living coordinating unit" means the senior living coordinating unit created within the Iowa department of elder affairs pursuant to Iowa Code section 231.58 as amended by 2000 Iowa Acts, Senate File 2193, section 13.

"Senior living program" means the Iowa senior living program established by 2000 Iowa Acts, Senate File 2193.

"Senior living trust fund" or *"trust fund"* means the Iowa senior living trust fund created by 2000 Iowa Acts, Senate File 2193, section 4, in the state treasury under the authority of the department.

441—161.2(249H) Funding and operation of trust fund.

161.2(1) *Moneys from intergovernmental agreements and other sources.* Moneys received by the department through intergovernmental agreements for the senior living program and moneys received by the department from other sources for the senior living trust fund, including grants, contributions, and participant payments, shall be deposited in the senior living trust fund.

161.2(2) *Use of moneys.* Moneys deposited in the trust fund shall be used only for the purposes of the senior living program as specified in 2000 Iowa Acts, Senate File 2193, and in rule 441—161.3(249H).

441—161.3(249H) Allocations from the senior living trust fund. Moneys deposited in the senior living trust fund shall be used only as provided in appropriations from the trust fund to the department of human services and the department of elder affairs and for purposes, including the awarding of grants, as specified in 2000 Iowa Acts, Senate File 2193, section 6, and in 441—Chapter 162.

441—161.4(249H) Participation by government-owned nursing facilities.

161.4(1) *Participation agreement.* Iowa government-owned nursing facilities participating in the Iowa Medicaid program and wishing to participate in the funding of the senior living trust fund shall contact the Department of Human Services, Office of Deputy Director for Policy, Fifth Floor, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114, for information regarding the conditions of participation. Upon acceptance of the conditions of participation, the facility shall sign Form 470-3763, Participation Agreement.

161.4(2) *Reimbursement.* Upon acceptance of the participation agreement, the department shall authorize increased reimbursement to the participating facility for nursing facilities services provided under the Medicaid program. The facility shall retain $5,000 of the additional reimbursement received during each state fiscal year as an administration fee. The facility shall refund the remainder of the additional reimbursement through intergovernmental transfer to the department for deposit of the federal share (less the $5,000 retained by the facility) in the Iowa senior living trust fund and the nonfederal share in the medical assistance appropriation.

These rules are intended to implement Iowa Code chapter 249H.

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CHAPTER 162
NURSING FACILITY CONVERSION AND LONG-TERM CARE SERVICES DEVELOPMENT GRANTS

PREAMBLE

These rules define and structure grants to be made from the Iowa senior living trust fund, hereafter referred to as the trust fund.

Grants are available to nursing facilities for capital or other one-time expenditure costs incurred for conversion of all or a portion of the facility to an assisted living facility or other alternatives to nursing facility care, and to noninstitutional providers of long-term care for development of other needed long-term care alternatives.

These rules implement provisions of Iowa Code chapter 249H, which establishes an overall goal of moving toward a balanced, comprehensive, affordable, high quality long-term care system.

441—162.1(249H) Definitions.

"Adult day care" means structured social, habilitation, and health activities provided in a congregate setting to alleviate deteriorating effects of isolation; to aid in transition from one living arrangement to another; to provide a supervised environment while the regular caregiver is working or otherwise unavailable; or to provide a setting for receipt of multiple health services in a coordinated setting.

"Affordable" means rates for payment of services that do not exceed the rates established for providers of medical and health services under the medical assistance program. In relation to services provided by a home- and community-based waiver services provider, "affordable" means that the total monthly cost of the home- and community-based waiver services provided do not exceed the maximum cost for that level of care as established by rule by the department.

In relation to assisted living, "affordable" means rates for the costs not paid by medical assistance are less than or equal to 110 percent of the maximum prevailing fair market rent for the same size apartment under guidelines of the applicable United States Department of Housing and Urban Development (HUD) low-rent housing program in the area where the assisted living program is located, plus 185 percent of the maximum federal supplemental security income benefit for an individual or couple (as applicable). Rates for the costs paid by medical assistance may not exceed the rates established for payment under the medical assistance home- and community-based services (HCBS) elderly waiver program.

"Assisted living program" means an assisted living program certified or voluntarily accredited by the Iowa department of elder affairs under Iowa Code chapter 231C.

"Child care for children with special needs" means physical, emotional, and social care delivered up to ten hours a day to children under the age of 18 by a service provider approved for participation in the medical assistance waivers in lieu of care by the parent or legal guardian.

"Department" means the Iowa department of human services.

"Director" means the director of the Iowa department of human services.

"Distinct portion of a nursing facility" means a clearly identifiable area or section within a nursing facility, consisting of at least a living unit, wing, floor, or building containing contiguous rooms.

"Efficient and economical care" means services provided within the reimbursement limits for the services under 441—subrule 79.1(2) for Medicaid home- and community-based services (HCBS) waivers and for less than the cost of comparable services provided in a nursing facility.

"Grantee" means the recipient of a grant.

"HCBS waivers" means Medicaid home- and community-based services waivers under 441—Chapter 83, which provide service funding for specific eligible consumer populations in Iowa.

"Long-term care alternatives" means those services specified under HCBS waivers as available services for elderly persons or adults with disabilities; elder group homes certified under Iowa Code chapter 231B; assisted living programs certified or voluntarily accredited under Iowa Code chapter 231C;

and the PACE program. These are services other than nursing facility care provided to the elderly and persons with disabilities.

"Long-term care service development" means either of the following:

1. The remodeling of existing space and, if necessary, the construction of additional space required to accommodate development of long-term care alternatives, excluding the development of assisted living programs or elder group home alternatives.

2. New construction for long-term care alternatives, excluding new construction of assisted living programs or elder group homes, if the senior living coordinating unit determines that new construction is more cost-effective for the grant program than the conversion of existing space.

"Medical assistance program" means the program established in Iowa Code chapter 249A and otherwise referred to as Medicaid or Title XIX.

"Nursing facility" means a licensed nursing facility as defined in Iowa Code section 135C.1 or a licensed hospital as defined in Iowa Code section 135B.1, a distinct part of which provides long-term care nursing facility beds.

"Nursing facility conversion" means either of the following:

1. The remodeling of nursing facility space existing on July 1, 1999, and certified for medical assistance nursing facility reimbursement and, if necessary, the construction of additional space required to accommodate an assisted living program.

2. New construction of an assisted living program if existing nursing facility beds are no longer licensed and the senior living coordinating unit determines that new construction is more cost-effective for the grant program than the conversion of existing space.

"PACE program" means a program of all-inclusive care for the elderly established pursuant to 42 U.S.C. Section 1396u-4 that provides delivery of comprehensive health and social services to seniors by integrating acute and long-term care services, and that is operated by a public, private, nonprofit, or proprietary entity. "Pre-PACE program" means a PACE program in the initial start-up phase that provides the same scope of services as a PACE program.

"Persons with disabilities" means persons 18 years of age or older with disabilities as disability is defined in Iowa Code section 225B.2.

"Respite care" means temporary care of an aged adult, or an adult or child with disabilities, to relieve the usual caregiver from continuous support and care responsibilities. Components of respite care services are supervision, tasks related to the individual's physical needs, tasks related to the individual's psychological needs, and social and recreational activities. A facility providing respite care must provide some respite care in the facility, but may also provide in-home respite.

"Safe shelter for victims of dependent adult abuse" means board, room, and services provided to persons identified by a department dependent adult abuse investigator as victims of dependent adult abuse.

"Senior" means elder as defined in Iowa Code section 231.4.

"Senior living coordinating unit" means the planning group established in Iowa Code section 231.58, or its designee.

"Senior living program" means the senior living program created by 2000 Iowa Acts, Senate File 2193, to provide for long-term care alternatives, long-term care service development, and nursing facility conversion.

"Trust fund" means the Iowa long-term care trust fund established by Iowa Code section 249H.4.

"Underserved area" means a county in which the number of currently licensed nursing facility beds and certified or accredited assisted living units is less than or equal to 4.4 percent of the number of individuals 65 years of age or older according to the most current census data. In addition, the department, in determining if a county is underserved, may consider additional information gathered through its own research or submitted by an applicant including, but not limited to, any of the following:

1. Availability of and access to long-term care alternatives relative to individuals eligible for medical assistance.

2. The current number of seniors and persons with disabilities and the projected number of these individuals.

3. The current number of seniors and persons with disabilities requiring professional nursing care and the projected number of these individuals.

4. The current availability of long-term care alternatives and any anticipated changes in the availability of these alternatives.

441—162.2(249H) Availability of grants. In any year in which funds are available for new nursing facility conversion or long-term care services development grants, the department shall issue a request for applications for grants. The amount of money granted shall be contingent upon the funds available. The use of funds appropriated to award grants shall be in compliance with legislation and at the direction of the senior living coordinating unit.

There is no entitlement to any funds available for grants awarded pursuant to this chapter. The department may award grants to the extent funds are available and, within its discretion, to the extent that applications are approved.

441—162.3(249H) Grant eligibility.

162.3(1) *Eligible applicants.* A grant applicant shall be:

a. A licensed nursing facility that has been an approved provider under the medical assistance program under the same ownership for the two-year period prior to application for the grant.

b. A provider of long-term care services, including one not covered by the medical assistance program, that has been in business for at least two years under the same owner.

162.3(2) *Types and amounts of grants.*

a. Architectural and financial feasibility study allowance. An architectural and financial feasibility study allowance may be awarded solely for costs directly attributable to development of the architectural and financial review documentation associated with conversion or service development. Architectural and financial feasibility study allowances for conversion or service development grants are limited to $15,000, not to exceed actual costs for each project.

b. Conversion grants. A conversion grant may be awarded to convert all or a portion of a licensed nursing facility to affordable certified assisted living units (limited to $45,000 per unit) and for capital or one-time expenditures including, but not limited to, start-up expenses, training expenses, and operating losses for the first year of operation following conversion.

Conversion grants are limited to a total of $1,000,000 per facility, with an additional $100,000 if the provider agrees to also provide adult day care, child care for children with special needs, safe shelter for victims of dependent adult abuse, or respite care.

A grant application which expands resident capacity of an existing nursing facility shall not be considered. A grant that requires additional space to accommodate supportive services related to the functioning of the long-term care alternative, such as dining rooms, kitchen and recreation areas, or other community-use areas, may be considered.

c. Long-term care services development grant. A long-term care services development grant may be awarded for capital or one-time expenditures to develop needed long-term care services covered under a Medicaid HCBS waiver or to develop a PACE program. Expenditures may include, but are not limited to, start-up expenses, training expenses, and operating losses for the first year of operation. Service development grants are limited to $1,000,000 per PACE program, and $150,000 for HCBS waiver services.

162.3(3) *Criteria for grant applicants.* A grant shall be awarded only to an applicant meeting all of the following criteria:

a. The applicant is located in an area determined by the senior living coordinating unit to be underserved with respect to a particular long-term care alternative service.

b. The applicant is able to provide a minimum matching contribution of 20 percent of the total cost of any conversion, remodeling, or construction. Costs used by grantees to match grant funds shall be directly attributable to the costs of conversion or service development.

c. Grant applications from nursing facilities shall be considered only from facilities with an established history of providing quality long-term care services. Facilities shall be in substantial

compliance with federal Medicaid participation requirements as evidenced at a minimum by all of the following:

(1) No identified deficiencies which pose a significant risk to resident health and safety at the time of application.

(2) No more than one isolated event resulting in actual harm to residents during the current Medicaid certification period.

(3) No citations for a pattern of events resulting in actual harm to residents for three years prior to application.

d. Grants to applicants other than nursing facilities shall be considered from applicants only when:

(1) There is substantial compliance with Medicare and Medicaid participation requirements or other applicable provider certification requirements at the time of application.

(2) Compliance exists with Medicare and Medicaid requirements, if applicable, for a three-year period prior to application.

(3) Compliance exists with the criminal background check system, if applicable.

e. The applicant agrees to do all of the following as applicable to the type of grant:

(1) Participate in the medical assistance program and maintain a medical assistance client participation rate of at least 40 percent, subject to the demand for participation by persons eligible for medical assistance. Applicants shall also agree that persons able to pay the costs of assisted living shall not be discharged from their living unit due to a change in payment source.

(2) Provide a service delivery package that is affordable for those persons eligible for services under the medical assistance home- and community-based services waiver program.

(3) Provide a refund of the grant to the senior living trust fund on a prorated basis if the applicant or the applicant's successor in interest: ceases to operate an affordable long-term care alternative within the first ten-year period of operation following the awarding of the grant; fails to maintain a participation rate of 40 percent in accordance with subparagraph (1) within the first ten-year period of operation following the awarding of the grant; or discharges persons able to pay the costs of assisted living from their living unit due to a change in payment source.

f. The applicant must demonstrate that the proposed method of construction, whether new or remodeling, is the most cost-effective for the grant program and, when developing assisted living units, must agree that a specified number of existing nursing facility beds will not continue to be licensed.

162.3(4) *Allowable and nonallowable costs.*

a. Examples of allowable costs include:

(1) Professional fees incurred specifically for conversion of facility or service development, including architectural, financial, legal, human resources, research, and marketing fees.

(2) Construction costs for the remodeling of existing space and, if necessary, the construction of additional space required to accommodate assisted living program services or other alternatives to nursing facility care or new construction of an assisted living facility or other alternative to nursing facility care if existing nursing facility beds are no longer licensed and the department determines that new construction is more cost-effective for the grant program than the conversion of existing space.

(3) Start-up and training expenses and operating losses for the first year.

b. Examples of nonallowable costs include:

(1) Costs of travel, personal benefits, and other facility programs or investments.

(2) Construction costs to remodel nursing facility space that will remain in use for nursing facility care.

(3) Any costs associated with operation and maintenance of a non-grant-related facility or service.

(4) Any costs incurred above per-unit grant amounts.

441—162.4(249H) Grant application process.

162.4(1) *Public notice of grant availability.* When funds are available for new grants, the department shall announce through public notice the opening of a competitive application period. The announcement shall include information on how agencies may obtain an application package and the deadlines for submitting an application.

162.4(2) *Request for applications.* The department shall distribute grant application packages for nursing facility conversion and long-term care service development grants upon request. Applicants desiring to apply for a grant shall submit Form 470-3759, Application for Nursing Facility Conversion Grant, or Form 470-3760, Application for Long-Term Care Service Development Grant, with accompanying documentation to the department by the date established in the application package. If an application does not include the information specified in the grant application package or if it is late, it will be disapproved.

The application must be submitted by the legal owner of the nursing facility or long-term care provider. In cases in which the provider licensee does not hold title to the real property in which the service is operated, both the licensee and the owner of the real property must submit a joint application. Form 470-3759 or Form 470-3760 must be signed by an individual authorized to bind the applicant to perform legal obligations. The title of the individual must be stated.

162.4(3) *Application requirements.*

a. Prior to submission of an application, the applicant must arrange and conduct a community assessment and solicit public comment on the plans proposed in the grant application. In soliciting public comment the applicant must at a minimum:

(1) Publish an announcement in a local or regional newspaper of the date, time, and location of a public meeting regarding the proposed project, with a brief description of the proposed project.

(2) Post notice of the meeting at the nursing facility or applicant's offices and at other prominent civic locations.

(3) Notify potentially affected clients and their families of the proposed project, of the potential impact on them, and of the public meeting at least two weeks prior to the public meeting.

(4) Advise the department of the public meeting date at least two weeks before the scheduled meeting.

(5) Address the following topics at the public meeting: a summary of the proposed project, the rationale for the project, and resident retention and relocation issues.

(6) Receive written and oral comments at the meeting and provide for a seven-day written comment period following the meeting.

(7) Summarize all comments received at the meeting or within the seven-day written comment period and submit the summary to the department as part of the application package.

b. Grant applications shall contain, at a minimum, the following information:

(1) Applicant identification and a description of the agency and its resources, which will demonstrate the ability of the applicant to carry out the proposed plan.

(2) Information to indicate the nursing facility applicant's extent of conversion of all or a portion of its facility to an assisted living program or development of other long-term care alternatives. Current and proposed bed capacity shall be given as well as the number of beds to be used for special services. Nursing facility and noninstitutional providers shall describe outpatient services they wish to develop.

(3) A request for an architectural and financial feasibility study allowance, if desired.

(4) Demonstration at a minimum of the following:

1. Public support for the proposal exists. Evidence of public support shall include, but not be limited to, the following: the summary of all comments received at the public meeting or within the seven-day written comment period and letters of support from the area agency on aging; the local board of health; local provider or consumer organizations such as the local case management program for frail elders, resident advocate committee or Alzheimer's chapter; and consumers eligible to receive services from the developed long-term care alternative.

2. The proposed conversion or service development will have a positive impact on the overall goal of moving toward a balanced, comprehensive, high-quality long-term care system.

3. Conversion of the nursing facility or a distinct portion of the nursing facility to an assisted living program or development of an alternative service will offer efficient and economical long-term care services in the service area described by the applicant.

4. The assisted living program or other alternative services are otherwise not likely to be available in the service area described by the applicant for individuals eligible for services under the medical assistance program.

5. If applicable, a resulting reduction in the availability of nursing facility services will not cause undue hardship to those individuals requiring nursing facility services for a period of at least ten years.

6. Conversion to an assisted living program or development of other alternative services will result in a lower per-client reimbursement to the grant applicant under the medical assistance program.

7. The service delivery package will be affordable for individuals eligible for services under the medical assistance home- and community-based services waiver program.

8. Long-term care alternatives will be available and accessible to individuals eligible for medical assistance and other individuals with low or moderate income.

9. Long-term care alternative services are needed based on the current and projected numbers of seniors and persons with disabilities, including those requiring assistance with activities of daily living in the service area described by the applicant.

10. Long-term care alternatives in the service area are needed based on the community needs assessment and upon current availability and any anticipated changes in availability.

162.4(4) *Selection of grantees.* All applications received by the department within the designated time frames and meeting the criteria set forth in rule 441—162.3(249H) and subrule 162.4(3) shall be reviewed by the department under the direction of the senior living coordinating unit.

If grant applications that meet the minimum criteria exceed the amount of available funds, scoring criteria shall be used to determine which applicants shall receive a grant. Scoring shall be based on the following:

1. The degree to which the county or counties in the service area described by the grant applicant are underserved - up to 20 points. If more than one county is in the service area, a weighted average shall be used.

2. The level of community support as identified by the community-based assessment, public meeting comments, and letters of support and the degree of collaboration among local service providers - up to 20 points.

3. For conversion grants, the number of licensed beds eliminated or converted to special needs beds, with evidence that the resulting reduction in licensed beds will not cause a hardship for persons requiring nursing services - up to 20 points.

4. The number of added services to fill a service need gap - up to 20 points.

5. Evidence of an adequate plan to carry out the requirements of this chapter and regulations pertaining to the long-term care alternative service - up to 20 points.

6. Costs of long-term care alternative services to consumers - up to 30 points.

7. Evidence of the ability and commitment to make proposed alternatives accessible to low- and moderate-income persons - up to 20 points.

162.4(5) *Notification of applicants.* Applicants shall be notified whether the grant proposal is approved or denied. Denial of an application in one year does not preclude submission of an application in a subsequent year.

441—162.5(249H) Grant dispersal stages. Following approval of an applicant's grant proposal by the department, the grant process shall proceed through the following stages:

162.5(1) *Completion of architectural and financial feasibility study.*

a. An architectural and financial feasibility study shall be completed pursuant to the guidelines included in the applicable grant application package and applicable service regulations.

(1) For facility conversion, construction, or remodeling, the architectural plan shall provide schematic drawings at a minimum of one-eighth scale consisting of the building site plan, foundation plan, floor plan, cross section, wall sections, and exterior elevations.

(2) The grantee shall comply with all local, state and national codes pertaining to construction; and certification, licensure, or accreditation requirements applicable to the long-term care alternative.

(3) Construction documents, budget cost estimates, and related services must be rendered by a professional architect or engineer registered in Iowa.

b. Payment of up to $15,000 may be issued to each approved applicant to proceed with the architectural and financial feasibility study if requested in the original application. By making a request for an architectural and financial feasibility study allowance, the applicant agrees that the funds will be used solely for costs directly attributable to development of the architectural and financial review documentation associated with conversion or service development.

c. All grantees must submit the completed study documents within the time frame identified in the request for application together with an itemized accounting of the expenditure of any allowance funds. Any unexpended architectural and financial review allowance funds shall be returned to the department.

162.5(2) *Review of architectural and financial feasibility study.* The department shall review the architectural and financial feasibility study materials and shall grant or deny approval to develop or obtain final budget estimates for the proposed project. Approval to proceed shall be granted only if the architectural and financial feasibility study supports the ability of the grantee to meet the minimum grant criteria and to complete the proposed project as set forth in the original application.

162.5(3) *Completion of final budget estimate.* Grantees approved to proceed with the final budget estimate shall submit the final budget estimates, any revisions to previously submitted materials, and a request for a grant in a specific amount. The matching fund amount to be paid by the grantee must be stated in the request.

162.5(4) *Review of final budget estimate.* The department shall review the final budget estimate and issue a notice of award for a grant in a specific amount if the final budget estimate supports the ability of the grantee to meet the minimum grant criteria and to complete the proposed project as set forth in the original application.

441—162.6(249H) Project contracts. The funds for approved applications shall be awarded through a contract entered into by the department and the applicant.

441—162.7(249H) Grantee responsibilities.

162.7(1) *Records and reports.*

a. The grantee shall maintain the following records:

(1) Consumer participation records that identify persons by payment source.

(2) Complete and separate records regarding the expenditure of senior living trust funds for the grant amounts received.

b. Recipients of grants shall submit a bimonthly progress report to the department and senior living coordinating unit beginning the second month following project approval through project completion.

c. Recipients shall submit annual cost reports to the department, in conformance with policies and procedures established by the department, regarding the project for a period of ten years after the date the grantee begins operation of its facility as an assisted living facility or other long-term care alternative.

162.7(2) *Reasonable access.* The grantee shall allow access to records at reasonable times by duly authorized representatives of the department for the purpose of conducting audits and examinations and for preparing excerpts and transcripts. This access to records shall continue for a period of ten years from the date the grantee begins operation as an assisted living facility or other long-term care alternative.

162.7(3) *Relinquishment of license.* The grantee shall relinquish the nursing facility bed license for any facility space converted to assisted living or alternatives to nursing facility care for a ten-year period.

162.7(4) *Acceptance of financial responsibility.* The grantee shall accept financial responsibility for all costs over and above the grant amount which are related to project completion.

162.7(5) *Participation in the medical assistance program.* The grantee shall participate in the medical assistance program as a provider of nursing facility services if the grantee continues to provide any nursing facility services.

162.7(6) *Segregation of medical assistance residents forbidden.* The grantee shall not segregate medical assistance residents in an area, section, or portion of an assisted living program or long-term care alternative service. Grantees shall allow a resident who is converting from private-pay to medical

assistance to remain in the resident's living unit if the resident is able to pay the rate and shall not relocate the resident solely due to a change in payment source.

441—162.8(249H) Offset. The department may deduct the amount of any refund due from a grantee from any money owed by the department to the grantee or the grantee's successor in interest.

441—162.9(249H) Appeals. Applicants dissatisfied with the department's actions regarding applications for grants and grantees dissatisfied with actions regarding a grant may file an appeal with the director. The letter of appeal must be received by the director within five working days of the date of the notice and must include a request for the director to review the action and the reasons for dissatisfaction. Within ten working days of the receipt of the appeal, the director shall review the appeal request and issue a final decision.

No disbursements shall be made to any applicant for a period of five working days following the notice awarding the original grants. If an appeal is filed within the five days, all disbursements shall be held pending a final decision on the appeal.

These rules are intended to implement Iowa Code section 249H.6 as amended by 2001 Iowa Acts, House File 740, section 7.

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CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES TO PREGNANT AND PARENTING ADOLESCENTS PROGRAMS

PREAMBLE

These rules define and structure the grant programs for adolescent pregnancy prevention statewide campaign, adolescent pregnancy evaluation, adolescent pregnancy state coalition, and community adolescent pregnancy prevention and services programs. The services are to be provided to adolescents and their parents for the purpose of preventing adolescent pregnancy; to adolescents who are either pregnant or parenting to prevent subsequent pregnancies, promote self-sufficiency and physical and emotional well-being; and to communities to assist them in addressing issues of adolescent pregnancy.

441—163.1(234) Definitions.

"Adolescent" means a person under 18 years of age or a person 18 years of age or older who is attending an accredited high school or pursuing a course of study which will lead to a high school diploma or its equivalent.

"Community" means a defined service area no smaller than a neighborhood and no larger than a region of the state.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services or successor agency.

"Grant designation committee" means the body which is responsible for designating and awarding grants.

"Grantee" or *"provider"* means an applicant who has received a grant.

"Percentage of pregnancies" means the total number of births to mothers aged 13 years of age and older but younger than 18 years of age in the service area for the most recent year for which data is available divided by the total number of births statewide for the same age group and the same year.

"Pregnancy prevention" means activities to avoid initial pregnancies.

"Prevention of subsequent pregnancy" means activities to avoid additional pregnancies during the adolescent years.

"Region" means one of the five department regions in the state.

441—163.2(234) Availability of grants for projects. In any year in which funds are available for adolescent pregnancy prevention statewide campaign, evaluation, coalition or community teen pregnancy prevention and services programs, the department shall administer grants to eligible applicants for projects that serve residents of Iowa. The amount of money granted shall be contingent upon the funds available and shall be made on an annual basis. The allocation of funds shall be in compliance with legislation and approved by the grant designation committee and the administrator of the division of adult, children, and family services.

441—163.3(234) Project eligibility.

163.3(1) Grants will be awarded to eligible applicants for specifically designed projects. Preference in awarding grants shall be given to projects which use a variety of community resources and agencies. Priority in awarding of points for community grants shall be given to programs that serve areas of the state which demonstrate the highest percentage of pregnancies of females aged 13 years of age or older but younger than the age of 18 within the geographic area to be served by the grant. Projects selected for the adolescent pregnancy prevention statewide campaign, adolescent pregnancy evaluation grant, and state coalition grants will be eligible for noncompetitive funding for up to three years, pending availability of funds and based upon satisfactory progress toward program goals. Projects which do not make satisfactory progress toward program goals shall be required to competitively bid for refunding. After three years, all projects must competitively bid for refunding.

Projects funded prior to July 2000 under the community adolescent pregnancy prevention and services grants are eligible for funding for up to nine years, pending availability of funds if the programs are comprehensive in scope and have demonstrated positive outcomes. Grants awarded after July 2000 must be comprehensive in scope and be based on existing models that have demonstrated positive outcomes.

An increasing grantee match will be required. A 5 percent grantee match will be required in year one. The match will increase by 5 percent each subsequent year a project receives funding. In-kind matches may be applied toward the grantee match. Projects which do not make satisfactory progress toward program goals shall be required to competitively bid for refunding.

163.3(2) A grantee may not use grant funds to serve residents of states other than Iowa. An exception to this would be a media campaign in which radio or television messages may "reach" audiences outside of Iowa.

163.3(3) Rescinded IAB 7/6/94, effective 7/1/94.

163.3(4) Projects must serve adolescents. Persons who were served prior to age 18 may continue to be served even though they are not currently pursuing a high school diploma.

163.3(5) Rescinded IAB 7/6/94, effective 7/1/94.

163.3(6) Eligible applicants for the statewide campaign are public or private agencies or individuals. Eligible applicants for the evaluation program are organizations or individuals affiliated with institutions under the authority of the state board of regents or other organizations or individuals experienced in evaluation techniques. Applications for the state coalition program will be accepted from groups or networks with statewide representation focusing on issues of adolescent pregnancy prevention, parenting and community collaboration. Applications for the community adolescent pregnancy prevention and services program will be accepted from community or regional boards or committees with broad-based representation or a single agency representing a broad-based group.

163.3(7) Rescinded IAB 11/4/98, effective 1/1/99.

163.3(8) Rescinded IAB 11/4/98, effective 1/1/99.

163.3(9) An adolescent pregnancy prevention statewide campaign grant will be awarded for a project providing a statewide campaign which encourages abstinence and provides information which will emphasize prevention of adolescent pregnancies.

163.3(10) An adolescent pregnancy prevention evaluation grant will be awarded to provide technical assistance to grantees in assessing their project and developing an evaluation tool for ongoing use. The evaluation grantee will provide an annual written report to the department.

163.3(11) A state coalition grant will be awarded to provide assistance to an existing coalition or network focusing on the issues of adolescent pregnancy prevention and services and coalition building in the state.

163.3(12) Community adolescent pregnancy prevention grants will be awarded to projects providing:

a. Broad-based representation from community or regional representatives including, but not limited to, schools, churches, human service-related organizations, and businesses.

b. Comprehensive programming focusing on the prevention of initial pregnancies during the adolescent years. Projects may provide one or more of the following services:

(1) Workshops and informational programs for adolescents and parents of adolescents to improve communication between children and parents regarding human sexuality issues.

(2) Programs that focus on the prevention of initial pregnancies through responsible decision making in relationships. These programs should be comprehensive with emphasis on, but not limited to, abstinence, risks associated with drug and alcohol use, contraceptives and associated failure rates, sexually transmitted diseases, and AIDS.

(3) Programs which use peer counseling or peer education techniques for the prevention of adolescent pregnancies.

(4) Development and distribution of informational material designed to discourage adolescent sexual activity, to provide information regarding acquired immune deficiency syndrome and sexually

transmitted diseases, and to encourage male and female adolescents to assume responsibility for their sexual activity and parenting.

c. Services to pregnant and parenting adolescents. Not more than 25 percent of a community grant may be used for these services. Projects may provide one or more of the following services:

(1) Programs intended to prevent an additional pregnancy by a parent who is less than 19 years of age. Preference in grant awards will be given to programs providing incentives to clients for their program participation and success in avoiding a subsequent pregnancy.

(2) Programs for pregnant or parenting teens intended to educate adolescents concerning the risks associated with alcohol and other drug use during pregnancy, improve parenting skills, and plan for the future.

(3) Programs for young fathers.

(4) Development and distribution of informational material designed to encourage male and female adolescents to assume responsibility for their sexual activity and parenting.

441—163.4(234) Request for proposals for pilot project grants.

163.4(1) The department will announce through public notice the opening of an application period for each of the grant programs. Applicants for grants shall request an Adolescent Pregnancy Prevention Application Kit for any or all of the open categories and shall submit grant proposals by the deadline specified in the announcement.

163.4(2) Requirements for project proposals are specified in the "Adolescent Pregnancy Prevention Grant Application Kit." If a proposal does not contain the information specified in the application package or if it is late, it will be disapproved. Proposals shall contain the following information:

a. General information.

b. Proposal checklist.

c. Proposal summary.

d. Statement of problem and need, including information demonstrating the percentage of pregnancies of females aged 13 years of age or older but younger than the age of 18 within the geographic area to be served.

e. Community or regional background information and demonstrated effectiveness at collaboration.

f. Project goals, objectives and methods.

g. Project monitoring and evaluation.

h. Budget information.

i. Explanation of grantee share of budget.

j. Future funding.

k. Cooperative agencies agreement.

l. Applicant assurances and certification.

m. Letters of support.

n. Project advisory committee.

441—163.5(234) Selection of proposals.

163.5(1) All proposals received will be evaluated by the grant designation committee to determine which applicants will be awarded grants.

163.5(2) The following factors will be considered in selecting proposals:

a. The demonstrated need for the service in the program area(s) selected and assurance that the proposed project does not duplicate other services in the community.

b. The community support demonstrated and the coordination with other existing agencies and organizations providing services to the targeted population.

c. The general program structure including, but not limited to, how well goals can be met, how realistic the objectives are, services offered and likelihood of anticipated impact on the problem, experience serving similar populations, the administration of funds, stability of the requesting entity and the overall quality of the proposal in comparison to other proposals.

d. The plan for using the funds. Funds may not be used for construction, capital improvement or purchase of real estate.

e. Rescinded IAB 11/4/98, effective 1/1/99.

163.5(3) Weighted scoring criteria will be used to determine grant awards. The maximum number of points possible is 125. Determination of final point awards will be based on the following:

a. Proposal summary—10 points.

b. Statement of problem and need—15 points.

c. Community or regional background information and demonstrated effectiveness with coalition building—10 points.

d. Project goals, objectives and methods—15 points.

e. Project monitoring and evaluation—10 points.

f. Budget information, explanation of grantee share of budget, and cooperative agencies agreement—15 points.

g. Future funding and applicant assurances and certification—5 points.

h. Project advisory committee—10 points.

i. Overall quality and impact of program—10 points.

j. Letters of support—10 points.

k. Consideration of legislative priority area—15 points.

441—163.6(234) Project contracts. The funds for approved applications will be awarded through a contract entered into by the director and the applicant. The contract period shall not exceed the state fiscal year in which the contract is awarded. The state fiscal year is from July 1 to June 30. Expenditures shall be reimbursed monthly pursuant to regular reimbursement procedures of the state of Iowa. Grantees will submit a projected yearly expenditure on April 15. Those projects expecting to spend more than 10 percent less than their granted amount shall free the excess for the purpose of providing supplemental funding to those grantees who wish to apply.

441—163.7(234) Records. Providers shall keep client and specific fiscal records of services provided and any other records as required by the department and specified in the contract.

441—163.8(234) Evaluation. The department shall evaluate the provider at least once prior to the end of the contract year to determine how well the purposes and goals are being met and shall provide ongoing feedback to the provider. Funds are to be spent to meet program goals as provided in the contract.

Grantees shall be required to submit quarterly reports. All grantees shall cooperate with the statewide evaluation grantee and provide all requested information. The evaluation grantee shall provide a written yearly report to the department.

441—163.9(234) Termination of contract. The contract may be terminated by either party at any time during the contract period by giving 30 days' notice to the other party.

163.9(1) The department may terminate a contract upon ten days' notice when the provider or any of its subcontractors fail to comply with the grant award stipulations, standards, or conditions.

163.9(2) Within 45 days of the termination, the provider shall supply the department with a financial statement detailing all costs up to the effective date of the termination.

163.9(3) The department shall administer the funds for this program contingent upon their availability. If the department lacks the funds necessary to fulfill its fiscal responsibility under this program, the contracts shall be terminated or renegotiated.

441—163.10(234) Appeals. Applicants dissatisfied with the grant designation committee's decision may file an appeal with the director. The letter of appeal must be received within ten working days of the date of the notice of decision; must be based on a contention that the process was conducted outside of statutory authority, violated state or federal law, policy or rule, did not provide adequate public notice, was altered without adequate public notice, or involved conflict of interest by staff or committee members; and must include a request for the director to review the decision and the reasons

for dissatisfaction. Within ten working days of the receipt of the appeal the director will review the appeal request and issue a final decision.

No disbursements will be made to any applicant for a period of ten calendar days following the notice of decision. If an appeal is filed within the ten days, all disbursements will be held pending a final decision on the appeal. All applicants involved will be notified if an appeal is filed and given the opportunity to be included as a party in the appeal.

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 164
IOWA HOSPITAL TRUST FUND

PREAMBLE

These rules describe the Iowa hospital trust fund created by the Second Extraordinary Session of the Seventy-ninth General Assembly in 2001 Iowa Acts, House File 763, and explain how public hospitals can participate in a program for funding of the Iowa hospital trust fund.

441—164.1(249I) Definitions.

"Department" means the Iowa department of human services.

"Hospital" means hospital as defined in Iowa Code section 135B.1.

"Hospital trust fund" or *"trust fund"* means the Iowa hospital trust fund created by Iowa Code Supplement section 249I.4, in the state treasury under the authority of the department.

"Public hospital" means a hospital licensed pursuant to Iowa Code chapter 135B and governed pursuant to Iowa Code chapter 145A, 347, 347A, or 392.

441—164.2(249I) Funding and operation of trust fund. Net funds received by the department through intergovernmental agreements for the hospital trust fund and moneys received by the department from other sources for the hospital trust fund, including grants, contributions, and participant payments, shall be deposited in the hospital trust fund. Annual expenses that are incurred to operate the hospital trust fund shall be deducted from funds received as a result of intergovernmental agreements and other sources, before their deposit in the hospital trust fund.

441—164.3(249I) Allocations from the hospital trust fund. Moneys deposited in the hospital trust fund shall be used only for the purposes of the hospital trust fund as specified in Iowa Code Supplement section 249I.2 and as provided in appropriations from the trust fund to the department of human services as specified in Iowa Code Supplement section 249I.4.

441—164.4(249I) Participation by public hospitals.

164.4(1) *Participation agreement.* Iowa public hospitals that participate in the Iowa Medicaid program and wish to participate in the funding of the hospital trust fund shall contact the Department of Human Services, Office of the Deputy Director for Policy, Hoover State Office Building, Fifth Floor, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114, for information regarding the conditions of participation. Upon acceptance of the conditions of participation, the hospital shall sign Form 470-3932, Participation Agreement for Intergovernmental Transfer.

164.4(2) *Administration fee.* Upon acceptance of the participation agreement, the department shall authorize increased reimbursement to the participating facility for hospital services provided under the Medicaid program. Once every state fiscal year, the hospital shall retain $5,000 of the additional reimbursement received, as an administration fee. The hospital shall refund the remainder of the additional reimbursement through intergovernmental transfer to the department for deposit of the federal share (less the $5,000 retained by the hospital) in the Iowa hospital trust fund and the nonfederal share in the medical assistance budget.

164.4(3) *Limit on participation.* The department may limit participation by public hospitals to no more than the number needed to maximize the fund.

These rules are intended to implement Iowa Code Supplement section 249I.4.

[Filed 9/12/02, Notice 7/24/02—published 10/2/02, effective 12/1/02]

CHAPTER 165
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM
Rescinded IAB 9/8/10, effective 9/1/10

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

441—166.1(249A) Definitions.

"Eligible entities" means nursing facilities, state agencies, nursing facility advocacy groups, and other nursing facility stakeholder groups.

"Nursing facility" means a Medicaid-enrolled facility that is defined in 441—81.1(249A) as "facility."

"Quality improvement initiative" or *"initiative"* means an innovative project that prevents noncompliance or promotes compliance with state or federal requirements for nursing facilities and that directly or indirectly benefits nursing facility residents by enhancing their quality of life or quality of care.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.2(249A) Availability of grants. At the beginning of each calendar year, the department shall set aside an annual amount from the civil money penalty fund established pursuant to Iowa Code section 249A.19 to be awarded in the form of grants to eligible entities for approved quality improvement initiatives. At no time shall the grant set-aside cause the civil money penalty fund to drop below $1 million.

166.2(1) In any calendar year in which sufficient funds are available in the civil money penalty fund to support quality improvement initiative grants, the department shall issue a notice for applications for grants.

166.2(2) There is no entitlement to any funds available for grants awarded pursuant to this chapter. The department may award grants to the extent funds are available and, within its discretion, to the extent that applications are approved.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.3(249A) Requirements for applicants. Eligible entities wishing to apply for quality improvement initiative grants must meet the following requirements:

166.3(1) Eligible entities may submit an application on behalf of a specific facility, on behalf of a group of facilities, or on behalf of a stakeholder group. However, grant funds awarded shall be distributed to one distinct entity that shall be contractually responsible for the funds.

166.3(2) The applicant must demonstrate the capacity to carry out the initiative for which the grant is requested.

166.3(3) At the time of the application, a facility applicant must not have:

a. Any pending enforcement actions that could result in the closure of the facility;

b. Any outstanding sanctions by the Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services; or

c. Any outstanding or unresolved Class I violations.

166.3(4) An applicant previously awarded a quality improvement initiative grant that failed to achieve that initiative's intended goals or outcomes shall be ineligible to apply for a period of five years following that grant award. However, a grant may be considered if the applicant's inability to complete the initiative was due to circumstances beyond the applicant's control.

166.3(5) An applicant may receive a maximum of two grants within a five-year period.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.4(249A) Requirements for initiatives. Grants are available only for quality improvement initiatives that are outside the scope of normal operations for the nursing facility or other applicant. Grants cannot be used as replacement funding for goods or services that the applicant already offers.

166.4(1) The applicant must be able to identify:

a. Areas in need of improvement, including staff education or training needs not available through current corporate or facility contract employment; and

b. Efficient uses of the quality improvement initiative grant to improve the quality of life or quality of care of nursing facility residents.

166.4(2) Grants may be awarded for:

a. Short-term quality improvement initiatives (three years or less), and

b. Initiatives with a longer term that involve collaborative efforts of state government and various stakeholders.

166.4(3) The applicant shall not submit a request for or receive a grant for the same type of initiative previously awarded a grant.

166.4(4) Except for a one-time initiative, grant awards shall be restricted to initiatives that will be self-sustaining once implemented. Costs to maintain the initiative may be considered allowable costs on the nursing facility's financial and statistical report, subject to 441—subrule 81.10(1) and rule 441—81.6(249A).

166.4(5) Quality improvement initiative grants are not available for the following:

a. General operations or administrative salaries.

b. Capital improvements, construction projects or other activities that would increase square footage or result in an increase in the assessed value of any property.

c. Facility maintenance activities intended to meet the minimum standards for nursing facilities set forth in 481—Chapter 61.

d. Goods or services for which the applicant or others are already obligated to pay.

e. Vendor payments and payroll obligations for a facility's normal operations or for fulfillment of state or federal requirements.

f. Costs related to travel, bonuses or other direct employee benefits.

g. Costs that are not specifically outlined in the applicant's grant application or are already included in the facility's cost report.

h. Projects, programs, goods or services that are unrelated to improving the quality of life or quality of care of nursing facility residents.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.5(249A) Applications. Eligible entities shall apply for quality improvement initiative grants using Form 470-4869, Grant Award Application. Applications may be accessed electronically through the Iowa Medicaid enterprise Web site, www.ime.state.ia.us/Providers.

166.5(1) Grant applications must be received by the Iowa Medicaid enterprise between February 1 and April 30 of any calendar year in which grant funds are available. Grant applications submitted before or after this period shall not be considered.

166.5(2) To be considered, each application must include, at a minimum, the following:

a. A description of the initiative's vision or goal. The application must identify how the grant will improve the quality of care or quality of life of nursing facility residents.

b. The objectives or expected outcomes of the initiative.

c. An implementation plan.

d. An education plan. For initiatives intended to provide education or training to stakeholders, the applicant shall submit a plan for the development and execution of the training curriculum.

e. A sustainability plan. The application shall describe how the initiative is a one-time initiative or will be self-sustaining once the grant implementation period has ended.

f. A budget, with competitive quotes. Applicants must include three quotes for the cost of equipment, construction and labor for the quality improvement initiative. The quotes shall be from businesses that comply with federal, state and local laws as required for the health and safety of the residents of the nursing facility.

g. A monitoring plan. The application shall describe how the applicant will monitor and evaluate ongoing progress toward meeting the initiative's stated goals.

h. The qualifications of professionals and other staff involved in the initiative.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.6(249A) Awarding of grants. Grants will be awarded beginning July 1 of each calendar year in which grant funds are available.

166.6(1) A grant award review committee shall be appointed by the state Medicaid director. The committee shall review and evaluate all complete grant applications submitted within the required time frame.

166.6(2) Applications shall be evaluated using the following criteria (indicated on Form 470-4869, Grant Award Application):

a. Vision or goal: 5 points.

b. Description of initiative: 20 points.

c. Effect on quality of care or quality of life of residents: 20 points.

d. Objectives and outcomes: 20 points.

e. Implementation plan: 25 points.

f. Education plan: 5 points.

g. Sustainability: 5 points.

166.6(3) Each grant application must score at least 85 points on the evaluation criteria for the application to be recommended to the department director for an award.

166.6(4) The department shall comply with the Centers for Medicare and Medicaid Services (CMS) guidance on whether specific categories of civil money penalty use require federal approval. The department shall submit the project plan for each grant the department intends to award, along with any required documentation, to CMS to seek approval or denial of the proposed project.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

441—166.7(249A) Grant requirements. Grant awards are subject to the following general requirements.

166.7(1) *Contract.* Grants for approved applications shall be awarded through a contract entered into by the department and the applicant. Grant funds shall be distributed to grantees in quarterly increments.

166.7(2) *Progress report.* The grantee shall submit quarterly progress reports following the date of the award until completion of the initiative. A grantee that fails to submit a quarterly progress report shall forfeit any future grant award distributions.

166.7(3) *Final report.* The grantee must submit a final report to the bureau of long term care of the Iowa Medicaid enterprise within 60 days of completion of the initiative.

a. The report shall be submitted on Form 470-4950, Grant Award Final Report.

b. The final report must provide evidence of successful completion of the quality improvement initiative and must address the following:

(1) The purpose of the grant,

(2) The expected outcomes of the initiative,

(3) The actual outcomes of the initiative,

(4) The number of residents who benefited from the initiative,

(5) The status of the action plan for sustainability if the initiative will continue beyond the grant funding.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

These rules are intended to implement Iowa Code section 249A.19.

[Filed Emergency After Notice ARC 9402B (Notice ARC 9157B, IAB 10/20/10), IAB 3/9/11, effective 4/1/11]

CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT
[Prior to 2/11/87, Human Services [498]]

DIVISION I
ANNUAL REIMBURSEMENT PROGRAM

441—167.1(232) Definitions.

"Allowable costs" means those expenses of the county or multicounty related to the establishment, improvements, operation, and maintenance of county or multicounty juvenile detention homes.

"County or multicounty" means that the governing body is a county board of supervisors or a combination of members of participating county boards of supervisors.

"Eligible costs" are those allowable costs that are directly attributable to the function of detaining youth in the home, from the point of intake through discharge from the home, as further defined in subrule 167.3(3).

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.2(232) Availability of funds. Any year that the Iowa legislature makes funds available for this program, the department shall accept requests for reimbursement from eligible facilities.

441—167.3(232) Eligible facilities. County and multicounty juvenile detention homes shall be eligible for reimbursement under this program when:

167.3(1) The home is approved by the department under the standards of Iowa Code chapter 232 and IAC 441—Chapter 105.

167.3(2) The home submits the following by May 15 of the year following the conclusion of the state fiscal year for which reimbursement will be made:

a. A written statement delivered in printed form or via electronic mail identifying the eligible total net cost that will be claimed under rule 441—167.5(232).

b. A printed or electronic copy of the following sections of Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts:

(1) Certification page.

(2) Schedule A, Revenue Report.

(3) Schedule C, Property and Equipment Depreciation and Related Party Property Costs.

(4) Schedule D, Expense Report.

c. A printed or electronic copy of the home's certified audit containing financial information for the period for which reimbursement is being claimed.

167.3(3) The department has reviewed the information submitted and determined that the costs to be claimed meet eligibility requirements. Eligible costs shall be determined by using a cost allocation methodology that follows generally accepted accounting principles (GAAP). Eligible costs shall be based on the portions of the allowable costs that are directly attributable to the function of detaining youth in the home.

a. Costs are not eligible for reimbursement if a supplemental funding, reimbursement, or refund source is available to the home. County payments to an eligible home for the function of detaining youth in the home ("care and keep") are not considered to be supplemental funding, reimbursement, or refund sources for the purpose of this subrule. Ineligible costs include, but are not limited to:

(1) Refundable deposits.

(2) Services funded by sources other than the juvenile detention reimbursement program.

(3) Operational activities such as the food and nutrition program that is funded by the Iowa department of education.

b. Costs attributed to portions of the home not directly used for detaining children are not eligible for reimbursement.

c. Costs of alternatives to detaining youth in the approved detention home are not eligible for reimbursement. Services ineligible for reimbursement include, but are not limited to:

(1) Community tracking and monitoring activities.
(2) Transportation not related to detention.
(3) Outreach services.
(4) In-home detention.

d. Capital expenses shall be depreciated over the useful life of the item following generally accepted accounting principles. The annual depreciated amount for items that are eligible costs may be claimed for reimbursement.

(1) Capital expenses shall include items costing more than $5,000 that have a useful life of over two years.

(2) Depreciation schedules shall be filed annually as needed.

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.4(232) Available reimbursement. The reimbursement for the participating facilities shall be the percentage of the allowable costs authorized in the appropriation language for the current fiscal year.

441—167.5(232) Submission of voucher. Eligible facilities shall submit a complete signed and dated Form GAX, General Accounting Expenditure, to the department to claim reimbursement.

167.5(1) Form GAX shall be submitted to the Department of Human Services, Division of Fiscal Management, First Floor, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, by August 10.

167.5(2) The form shall include the total net eligible costs incurred between July 1 and June 30 of the year covered by the reimbursement. The total net eligible costs will be used to calculate the legislatively authorized percentage of the home's allowable costs for the year covered by the reimbursement.

167.5(3) Only facilities that submit Form GAX by August 10 shall receive reimbursement.

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.6(232) Reimbursement by the department. Reimbursement shall be made by August 31 to those participating facilities which have complied with these rules.

These rules are intended to implement Iowa Code section 232.142.

441—167.7 to **167.10** Reserved.

DIVISION II
SEVENTY-TWO HOUR REIMBURSEMENT PROGRAM

Reserved

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CHAPTER 168
CHILD CARE EXPANSION PROGRAMS

[Prior to 6/28/89, see 441—Chapter 154]

PREAMBLE

These rules define and structure funding for wrap-around child care programs and expansion of school-age child care programs. The purpose of wrap-around funding is to provide continuity of services for children through programs that support core programs by expanding the day and continuing the services through breaks in the core program schedule. School-age expansion funding is intended to increase access to child care for school-age children before and after school.

441—168.1(234) Definitions.

"Administrator" means the administrator of the department's division of children and family services.

"Applicant" means any eligible entity that submits a proposal.

"Child care facility," for the purposes of this chapter, means a facility that is licensed or that has a license in process under Iowa Code chapter 237A or a child care program established by a school pursuant to Iowa Code section 279.49.

"Contractor" means the entity with which the department contracts for administration of child care expansion program funds.

"Core program" means a Head Start program, an Early Head Start program, a department of education at-risk program, a Title I preschool, an Even Start program, or an early childhood special education program.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services.

"Proposal review committee" means a committee appointed by the chief of the department's bureau of child care and community services to review proposals and make recommendations to the department.

"School-age child care program" means a program that provides child care to children who are between five years of age and 13 years of age by September 15 and who are enrolled in a public or approved nonpublic school program.

"School-age expansion funding" means funding that assists in meeting expansion needs for school-age child care programs. School-age expansion funds shall increase access to school-age child care for children before and after school and during the summer and other breaks in the regular school schedule.

"Wrap-around child care program" means a program that provides child care for children before and after a core program and during the summer and other breaks in the core program schedule. Wrap-around child care programs shall provide continuity of services for children who attend an eligible core program and whose families meet the eligibility guidelines for child care assistance as set forth in rule 441—170.2(237A,239B).

441—168.2(234) Availability of funds.

168.2(1) In any year in which funds are available for wrap-around child care programs or for both wrap-around child care programs and school-age child care expansion, the department shall administer awards to eligible applicants based on:

a. The availability of funds;

b. The applicant's history and demonstration of quality of services provided; and

c. The applicant's compliance with department requirements.

168.2(2) If sufficient eligible proposals are not received or available, the department reserves the right not to allocate all funds.

441—168.3(234) Eligibility requirements.

168.3(1) *Wrap-around child care funding.* Funds shall be awarded to entities administering child care programs that provide continuity of services with a core program as defined in this chapter. Collaborative proposals within communities are encouraged.

a. All wrap-around program slots shall be reserved for children:

(1) Who attend a core program; and

(2) Whose families meet the eligibility guidelines for child care assistance as set forth in rule 441—170.2(237A,239B) at the time of enrollment for each contract year.

b. Wrap-around child care funds shall be used to support costs of the child care provided before and after the core program, including summer and other breaks in the core program schedule, for one service period as specified in the contract.

c. Child care assistance funds shall not be used for a child during the time the child is attending a wrap-around child care program.

168.3(2) *School-age expansion funding.* Funds may be awarded to entities that administer a school-age child care program as defined in this chapter if the applicant shows that the funds will increase the number of school-age children served or will expand participation of school-age children with special needs.

441—168.4(234) Request for proposals. The department shall announce the request for proposal period through public notice.

168.4(1) *Proposal submittal.* All applicants shall submit proposals to: Iowa Department of Human Services, Bureau of Child Care and Community Services, Hoover State Office Building, Fifth Floor, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.

a. Proposals shall be in the form prescribed by the department.

b. To be eligible for review, the proposals shall be received by the due date specified in the request for proposals.

168.4(2) *Proposal requirements.* Requirements for proposals shall be specified in each request for proposals. A proposal that does not contain the information specified may be disqualified at the discretion of the department. Proposals shall describe how the program will improve services to children and shall include but not be limited to the following information:

a. Program description, including but not limited to:

(1) Stated goals and objectives of the program.

(2) Impact of proposal on children, families, and core program.

(3) Facility plan.

(4) Curriculum plan.

(5) Positive guidance plan.

(6) Health and safety plan.

(7) Food and nutrition plan.

(8) Evidence of an inclusive environment.

(9) Continuity of services plan.

(10) Staff plan.

(11) Professional development plan.

(12) Parental involvement plan.

b. Needs assessment:

(1) Geographical area to be served, including population density.

(2) Demographics of the service population.

(3) Socioeconomic data for the area served, such as indicators of poverty and teen pregnancy.

c. Description of community linkages and community collaboration.

d. Evidence of program quality and sustainability.

e. Proposed budget for the requested contract funds.

f. Evidence of required insurance coverage.

g. Other information identified in the request for proposals.

441—168.5(234) Selection of proposals. The administrator shall make the funding decisions.

168.5(1) *Review.* The department shall conduct a preliminary review of each proposal to ensure that the proposal is eligible for review by the proposal review committee. All eligible proposals received by the department shall be evaluated by the proposal review committee, which shall make funding recommendations to the administrator.

168.5(2) *Criteria.* The selection criteria shall be set forth in the request for proposals.

168.5(3) *Notice of decision.* Each applicant shall be notified within 60 days after the proposal due date whether the proposal has been denied or approved for funding and the amount of funds approved for the contract.

441—168.6(234) Appeals. Applicants dissatisfied with the department's decision may file a written appeal with the director. An appeal of a decision shall not stay contract negotiations with the apparent successful bidders.

168.6(1) The appeal must:

a. Be received within five working days of the date of the notice of decision;

b. Be based on a contention that the process:

(1) Was conducted outside of statutory authority;

(2) Violated state or federal law, policy, or rules;

(3) Did not provide adequate public notice;

(4) Was altered without adequate public notice; or

(5) Involved a conflict of interest by staff or committee members.

c. Include a request for the director to review the decision.

d. Include the reasons for the applicant's dissatisfaction.

168.6(2) Within ten working days of receipt of the appeal, the director shall review the appeal request and issue a final decision. An evidentiary hearing will not be conducted.

441—168.7(234) Contracts.

168.7(1) Before entering into a contract, the department may require modification of the program or budget, submission of further information or documents, or other stipulation of the applicant. The required modification, information, document, or stipulation shall be specified in the notification of contract award.

168.7(2) The department shall pay the contractor semiannually. The first payment shall be made after all parties have signed the contract. The second payment shall be made after the department has received, reviewed and approved the contractor's semiannual expenditure and performance report, as required in the contract. The contractor shall spend the funds only in accordance with the proposal approved by the department and as set forth in the contract.

168.7(3) The contractor shall keep records to document all services provided, as set forth in the contract. All records pertaining to programs funded by the contract shall be made available to the department upon request.

168.7(4) As specified in the contract, the contractor shall return unspent funds to the department with the submission of the final reports. Following the department review of the reports and contract delivery assessment, the department will determine if additional funds shall be returned.

168.7(5) Nothing in these rules shall be construed as limiting the remedies available to the state or the department for improper use of contract funds or other breach of the contractor's duties under the contract and applicable law.

441—168.8(234) Reporting requirements. Each contractor shall provide specified documents and information to the department to enable the department to evaluate the contractor, to monitor fiscal activity, and to ensure that the program goals are met.

168.8(1) The contractor shall submit expenditure reports at such times and in a format prescribed by the department as described in the contract.

168.8(2) The contractor shall submit performance reports at such times and in a format prescribed by the department as described in the contract.

168.8(3) Failure to submit a report by the due date shall result in suspension of department payment to the contractor until the report is received and approved. Delinquent or inadequate reports may negatively affect contracts or renewals for the following year.

168.8(4) The department may make monitoring visits to evaluate program management, fiscal accountability, and service delivery. The contractor shall receive a written report of the monitoring visit.

441—168.9(234) Termination of contract. Either party may terminate the contract at any time during the contract period by giving 60 days' notice to the other party.

168.9(1) The department may terminate a contract upon ten days' notice when the contractor fails to comply with the contract award stipulations, standards, or conditions.

168.9(2) Within 45 days of the termination of the contract, the contractor shall supply the department with a financial statement detailing all expenditures up to the effective date of the termination.

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 169
FUNDING FOR EMPOWERMENT AREAS

Rescinded **ARC 1444C**, IAB 4/30/14, effective 7/1/14

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, a nonregistered family child care home, or in a facility exempt from licensing or registration.

441—170.1(237A) Definitions.

"Agency error" means child care assistance incorrectly paid for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

"Child care" means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

"Child with protective needs" means a child who is not in foster care and has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. The child must have:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

"Child with special needs" means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

"Client" means a current or former recipient of the child care assistance program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

"Department" means the Iowa department of human services.

"Food services" means the preparation and serving of nutritionally balanced meals and snacks.

"Fraudulent means" means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

"In-home" means care which is provided within the child's own home.

"Migrant seasonal farm worker" means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.
2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.
3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

"On-line or distance learning" means training such as, but not limited to, training conducted over the Iowa communications network, on-line courses, or Web conferencing. The training includes:

1. Interaction between the instructor and the student, such as required chats or message boards;
2. Mechanisms for evaluation and measurement of student achievement.

"Overpayment" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"Parent" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"Program and activities" means the daily schedule of experiences in a child care setting.

"PROMISE JOBS" means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93.

"Provider" means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, a nonregistered child care home, or a child care facility which is exempt from licensing or registration.

"Provider error" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

"Recoupment" means the repayment of an overpayment by a payment from the client or provider or both.

"Relative" means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

"Supervision" means the care, protection, and guidance of a child.

"Transportation" means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

"Unit of service" means a half day which shall be up to 5 hours of service per 24-hour period.

"Vocational training or education" means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

1. Training may be approved for high school completion activities, adult basic education, GED, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

2. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time plans may be approved only if the number of credit hours to complete training is less than full-time status, the required prerequisite credits or remedial course work is less than full-time status, or training is not offered on a full-time basis.

[**ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9651B**, IAB 8/10/11, effective 10/1/11]

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) *Financial eligibility.* Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa's median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. Income limits. For initial and ongoing eligibility, a family's nonexempt gross monthly income as established in paragraph 170.2(1)*"c"* cannot exceed:

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa's median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. Exceptions to income limits.

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. Determining gross income. Eligibility shall be determined using a projection of income based on the best estimate of future income. In determining a family's gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)*"d."*

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers' compensation, alimony, child support, veterans pensions, cash payments, casino profits,

railroad retirement, permanent disability insurance, strike pay and living allowance payments made to participants of the AmeriCorps program. "Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

(3) When income received weekly or once every two weeks is projected for future months, income shall be projected by adding all income received in the period being used for the projection and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

d. *Income exclusions.* The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food and Nutrition Act of 2008.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under the Workforce Investment Act (WIA).

(18) Stipends received for participating in the foster grandparent program.

(19) The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

(28) Federal or state earned income tax credit.

(29) Payments from the Iowa individual assistance grant program (IIAGP).

(30) Payments from the transition to independence program (TIP).

(31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program. EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

(32) Reimbursement from the employer for job-related expenses.

(33) Stipends from the preparation for adult living (PAL) program.

(34) Payments from the subsidized guardianship waiver program.

(35) The earnings of a child aged 18 or under who is a full-time student.

(36) Census earnings received by temporary workers from the Bureau of the Census.

(37) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

e. *Family size.* The following people shall be included in the family size for the determination of eligibility:

(1) Legal spouses (including common law) who reside in the same household.

(2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.

(3) A child or children who live with a person or persons not legally responsible for the child's support.

f. *Effect of temporary absence.* The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

(1) An absence for the purpose of education or employment.

(2) An absence due to medical reasons that is anticipated to last less than three months.

(3) Any absence when the person intends to return home within three months.

170.2(2) *General eligibility requirements.* In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

a. *Age.* Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19.

b. *Need for service.* Except for assistance provided under subparagraph 170.2(2)*"b"*(3), assistance shall be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Child care services may be provided for the parent's hours of participation in the academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two adjacent calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

2. Payment shall not be approved for child-care during training in the following circumstances:

- Labor market statistics for a local area indicate low employment potential for workers with that training. Exceptions may be made when the parent has a job offer before entering the training or

if a parent is willing to relocate after training to an area where there is employment potential. Parents willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the parent.

- The training is for jobs paying less than minimum wage.
- A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.
- The course or training is one that the parent has previously completed.
- The parent was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.
- The education is in a field in which the parent will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.
- The parent wants to participate in on-line or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment and for actual travel time between the child care location and the place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent has a child with protective needs for child care.

(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician.

1. Eligibility under this paragraph is limited to parents who become medically incapacitated while eligible for child care assistance based on the need criteria in subparagraph 170.2(2)*"b"*(1) or 170.2(2)*"b"*(2).

2. Child care assistance shall continue to be available for up to 30 consecutive days after the parent becomes medically incapacitated. Assistance beyond 30 days may be approved by the service area manager or designee if extenuating circumstances are verified by a physician.

3. The number of units of service authorized shall be determined as follows:

- For a single parent family or for a two-parent family where both parents are incapacitated, the number of units authorized for the period of incapacity shall not exceed the number of units authorized for the family before the onset of incapacity.
- For a two-parent family where only one parent is incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours shall be limited to only those hours the parent is actually looking for employment including travel time.

1. A job search plan shall be approved by the department and be limited to a maximum of 30 consecutive calendar days in a 12-month period. EXCEPTION: Additional job search hours may be paid for PROMISE JOBS participants if approved by the PROMISE JOBS worker.

2. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

c. Residency. To be eligible for child care services, the person must be living in the state of Iowa. "Living in the state" shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

d. Citizenship. As a condition of eligibility, the applicant shall attest to the child's citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0462(S), Health and Financial Support Application. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child's entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or

2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

e. Cooperation. Parents shall cooperate with the department when the department selects the family's case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

170.2(3) *Priority for assistance.* Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2)*"b"* except at review or redetermination.

170.2(4) *Reporting changes.* The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported, the effective date of the change shall be the date when the change is reported to the department office or PROMISE JOBS office.

[**ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9651B**, IAB 8/10/11, effective 10/1/11]

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) *Application process.*

a. Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application,

(2) Form 470-0462 or 470-0462(S), Health and Financial Support Application, or

(3) Form 470-4377 or 470-4377(S), Child Care Assistance Review, when returned after the end of the certification period.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received in the department office. An electronic or paper application delivered to a closed office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of no longer than six months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

170.3(2) *Exceptions to application requirement.* An application is not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.

c. Children with protective needs.

d. Child care services provided under a court order.

e. Families whose application has been denied for failure to provide requested information who have provided all necessary information to determine eligibility within 14 days of the denial of the application, or by the next working day if the fourteenth day falls on a weekend or state holiday.

170.3(3) *Application processing.* The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received. This time limit shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expires, or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility.

c. The effective date of assistance shall be the date of application or the date the need for service began, whichever is later. When an application is not required as described under subrule 170.3(2), the effective date shall be as follows:

(1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance shall be the date the person becomes a PROMISE JOBS participant as defined in rule 441—93.1(239B) or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance shall be no earlier than the effective date of family investment program benefits, or 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance shall be the date the family signs Form 470-0615 or 470-0615(S), Application for All Social Services.

(4) When child care services are provided under a court order, the effective date of assistance shall be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance shall be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information.

170.3(4) *Waiting lists for child care services.* When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* The department shall redetermine a family's financial and general eligibility for child care assistance at least every six months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP), persons whose earned income was taken into account in determining the needs of FIP recipients, and parents who have children with protective needs, because these families are deemed financially eligible so long as the FIP eligibility or need for protective services continues.

a. If FIP or protective services eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5)*"c."*

(1) The department shall issue a notice of expiration for the child care assistance certification period on Form 470-4377 or 470-4377(S).

(2) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6)*"b."* A complete review form is Form 470-4377 or 470-4377(S) with all items answered that is signed and dated by the applicant and is accompanied by all verification needed to determine continued eligibility.

c. Families who have children with protective needs and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete Form 470-4377 or 470-4377(S).

(1) The department shall issue a notice of expiration for the child care assistance certification period on the notice of decision when the department approves the family's certification period.

(2) The department shall gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6)*"b."*

d. Families who are receiving child care assistance because the parent is seeking employment are not subject to review requirements because eligibility is limited to 30 consecutive calendar days. This waiver of the review requirement applies only when the parent who is seeking employment does not have another need for service.

170.3(6) *Reinstatement.*

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

b. Assistance shall be reinstated without a new application when the case was canceled for failure to provide requested information but all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information. The effective date of child care assistance shall be the date that all information required to establish eligibility is provided.

[**ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9651B**, IAB 8/10/11, effective 10/1/11]

441—170.4(237A) Elements of service provision.

170.4(1) *Case file.* The child welfare case file shall document the eligibility for service under 170.2(2)*"b"*(3).

170.4(2) *Fees.* Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. *Sliding fee schedule.*

(1) The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2014:

	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
Level	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
A	$924	$1,245	$1,568	$1,889	$2,210	$2,532	$2,853	$3,174	$3,496	$3,817	$0.00	$0.00	$0.00
B	$973	$1,311	$1,650	$1,988	$2,326	$2,665	$3,003	$3,341	$3,680	$4,018	$0.20	$0.45	$0.70
C	$1,000	$1,348	$1,696	$2,044	$2,391	$2,740	$3,087	$3,435	$3,783	$4,131	$0.45	$0.70	$0.95
D	$1,027	$1,384	$1,742	$2,099	$2,456	$2,814	$3,171	$3,528	$3,886	$4,243	$0.70	$0.95	$1.20
E	$1,056	$1,423	$1,791	$2,158	$2,525	$2,893	$3,260	$3,627	$3,995	$4,362	$0.95	$1.20	$1.45
F	$1,085	$1,462	$1,840	$2,217	$2,594	$2,972	$3,349	$3,726	$4,104	$4,481	$1.20	$1.45	$1.70
G	$1,115	$1,503	$1,891	$2,279	$2,666	$3,055	$3,443	$3,830	$4,219	$4,606	$1.45	$1.70	$1.95
H	$1,146	$1,544	$1,943	$2,341	$2,739	$3,138	$3,536	$3,934	$4,334	$4,732	$1.70	$1.95	$2.20
I	$1,178	$1,587	$1,997	$2,407	$2,816	$3,226	$3,635	$4,044	$4,455	$4,864	$1.95	$2.20	$2.45

	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
Level	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
J	$1,210	$1,630	$2,052	$2,472	$2,892	$3,314	$3,734	$4,155	$4,576	$4,996	$2.20	$2.45	$2.70
K	$1,244	$1,676	$2,109	$2,541	$2,973	$3,407	$3,839	$4,271	$4,704	$5,136	$2.45	$2.70	$2.95
L	$1,278	$1,722	$2,167	$2,611	$3,054	$3,500	$3,943	$4,387	$4,832	$5,276	$2.70	$2.95	$3.20
M	$1,313	$1,770	$2,227	$2,684	$3,140	$3,598	$4,054	$4,510	$4,968	$5,424	$2.95	$3.20	$3.45
N	$1,349	$1,818	$2,288	$2,757	$3,225	$3,696	$4,164	$4,633	$5,103	$5,572	$3.20	$3.45	$3.70
O	$1,387	$1,869	$2,352	$2,834	$3,316	$3,799	$4,281	$4,763	$5,246	$5,728	$3.45	$3.70	$3.95
P	$1,425	$1,920	$2,416	$2,911	$3,406	$3,903	$4,397	$4,892	$5,389	$5,884	$3.70	$3.95	$4.20
Q	$1,465	$1,974	$2,484	$2,993	$3,501	$4,012	$4,521	$5,029	$5,540	$6,049	$3.95	$4.20	$4.45
R	$1,505	$2,027	$2,551	$3,074	$3,597	$4,121	$4,644	$5,166	$5,691	$6,213	$4.20	$4.45	$4.70
S	$1,547	$2,084	$2,623	$3,160	$3,698	$4,236	$4,774	$5,311	$5,850	$6,387	$4.45	$4.70	$4.95
T	$1,589	$2,141	$2,694	$3,246	$3,798	$4,352	$4,904	$5,456	$6,009	$6,561	$4.70	$4.95	$5.20
U	$1,633	$2,201	$2,770	$3,337	$3,905	$4,474	$5,041	$5,608	$6,178	$6,745	$4.95	$5.20	$5.45
V	$1,678	$2,261	$2,845	$3,428	$4,011	$4,596	$5,178	$5,761	$6,346	$6,929	$5.20	$5.45	$5.70
W	$1,725	$2,324	$2,925	$3,524	$4,123	$4,724	$5,323	$5,923	$6,523	$7,123	$5.45	$5.70	$5.95
X	$1,772	$2,387	$3,005	$3,620	$4,236	$4,853	$5,468	$6,084	$6,701	$7,317	$5.70	$5.95	$6.20
Y	$1,821	$2,454	$3,089	$3,721	$4,354	$4,989	$5,621	$6,254	$6,889	$7,522	$5.95	$6.20	$6.45
Z	$1,871	$2,521	$3,173	$3,823	$4,473	$5,125	$5,775	$6,425	$7,076	$7,726	$6.20	$6.45	$6.70
AA	$1,923	$2,592	$3,262	$3,930	$4,598	$5,268	$5,936	$6,604	$7,275	$7,943	$6.45	$6.70	$6.95
BB	$1,976	$2,662	$3,351	$4,037	$4,723	$5,412	$6,098	$6,784	$7,473	$8,159	$6.70	$6.95	$7.20

(2) To use the chart:

1. Find the family size used in determining income eligibility for service.

2. Move across the monthly income table to the column headed by that number. (See paragraph "5" if the family has more than ten members.)

3. Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.

4. Choose the fee that corresponds to the number of children in the family who receive child care assistance.

5. When a family has more than ten members, determine the income level by multiplying the figures in the four-member column for the rows closest to the family's income level by 0.03. Round the numbers to the nearest dollar and multiply by the number of family members in excess of ten. Add the results to the amounts in the ten-member column to determine the threshold amounts.

(3) EXAMPLES:

1. Family 1 has two members, monthly income of $1,250, and one child in care. Since the income is at or above the Level A amount but less than the Level B amount, Family 1 pays $0.00 for each unit of child care service that the child receives.

2. Family 2 has three members, monthly income of $1,650, and one child in care. Since the income is at or above the Level B amount but less than the Level C amount, Family 2 pays $0.20 for each unit of child care service that the child receives.

3. Family 3 has three members, monthly income of $1,650, and two children in care. The younger child receives ten units of child care service per week. The older child is school-aged and receives only five units of service per week. Since the income is at or above the Level B amount but less than the Level C amount, Family 3 pays $0.45 for each unit of child care service that the younger child receives.

b. *Collection.* The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) *Method of provision.* Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)*"b"*(3), as long as the conditions in paragraph 170.4(7)*"d"* are met. When the child meets the need for service under 170.2(2)*"b"*(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. Registered family child care home. Rescinded IAB 1/7/04, effective 3/1/04.

d. Relative care. Rescinded IAB 2/6/02, effective 4/1/02.

e. In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and

that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

g. Exempt facilities. Child care facilities operated by or under contract to a public or nonpublic school accredited by the department of education that are exempt from licensing or registration may receive payment for child care services when selected by a parent.

h. Iowa records checks for nonregistered child care homes and in-home care. If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit to the department Form 470-5143, Iowa Department of Human Services Record Check Authorization Form, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The department shall use this form to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

(3) Records checks shall be repeated for each person subject to the check every two years and when the department or provider becomes aware of any new transgressions committed by that person.

i. National criminal history record checks for nonregistered child care homes and in-home care. If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45, Waiver Agreement, and Form FD-258, Federal Fingerprint Card, for the provider, for anyone 18 years of age or older who is living in the home, or for anyone having access to a child when the child is alone.

(1) The provider or other person subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider or other person subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

j. Transgressions. If any person subject to the record checks in paragraph 170.4(3)*"h"* or 170.4(3)*"i"* has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 110.7(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) *Components of service program.* Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) *Levels of service according to age.* Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) *Provider's individual program plan.* Rescinded IAB 2/10/10, effective 3/1/10.

170.4(7) *Payment.* The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S), Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker shall sign this form.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)*"d,"* shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for "child with special needs," and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Table I
Half-Day Rate Ceilings for Basic Care

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$16.78	$12.98	$12.44	$8.19
Preschool	$13.53	$12.18	$12.18	$7.19
School Age	$12.18	$10.82	$10.82	$7.36

Table II
Half-Day Rate Ceilings for Special Needs Care

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$51.94	$17.05	$13.40	$10.24
Preschool	$30.43	$15.83	$13.40	$ 8.99
School Age	$30.34	$14.61	$12.18	$ 9.20

The following definitions apply in the use of the rate tables:

(1) "Child care center" shall mean those providers as defined in 170.4(3)*"a"* and *"g."* "Registered child development home" shall mean those providers as defined in 170.4(3)*"b."* "Nonregistered family child care home" shall mean those providers as defined in 170.4(3)*"f."*

(2) Under age group, "infant and toddler" shall mean age two weeks to two years; "preschool" shall mean two years to school age; "school age" shall mean a child in attendance in full-day or half-day classes.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. *Payment for multiple children in a family.* When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. *Payment for in-home care.* Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. *Limitations on payment.* Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. *Review of the calculation of the rate of payment.* Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7)*"a"* may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

g. *Submission of claims.* The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay for no more than the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(2) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[**ARC 7837B**, IAB 6/3/09, effective 7/1/09; **ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9490B**, IAB 5/4/11, effective 7/1/11; **ARC 9651B**, IAB 8/10/11, effective 10/1/11; **ARC 0152C**, IAB 6/13/12, effective 7/18/12; **ARC 0546C**, IAB 1/9/13, effective 1/1/13; **ARC 0715C**, IAB 5/1/13, effective 7/1/13; **ARC 0825C**, IAB 7/10/13, effective 7/1/13; **ARC 0854C**, IAB 7/24/13, effective 7/1/13; **ARC 1063C**, IAB 10/2/13, effective 11/6/13; **ARC 1446C**, IAB 4/30/14, effective 7/1/14]

441—170.5(237A) Adverse actions.

170.5(1) *Provider agreement.* The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), if any of the following occur:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazard.

b. The provider has submitted claims for payment for which the provider is not entitled.

c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

d. The provider does not meet one of the applicable requirements set forth in subrule 170.4(3).

170.5(2) *Denial.* Child care assistance shall be denied when the department determines that:

a. The client is not in need of service; or

b. The client is not financially eligible; or

c. There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or

d. An application is required and the client or representative refuses or fails to sign the application form; or

e. Funding is not available; or

f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(3) *Termination.* Child care assistance may be terminated when the department determines that:

a. The client no longer meets the eligibility criteria in subrule 170.2(2); or

b. The client's income exceeds the financial guidelines; or

c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

e. Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or

f. Funding is not available; or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(4) *Reduction.* Authorized units of service may be reduced when the department determines that:

a. Continued provision of service at the current level is not necessary to meet the client's service needs; or

b. Another resource is available to provide the same or similar service free of charge that will meet the client's needs and allow parents to select from the full range of eligible providers; or

c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

[**ARC 7740B**, IAB 5/6/09, effective 6/10/09; **ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9651B**, IAB 8/10/11, effective 10/1/11]

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) *Fraud.* The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of $1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of $1,000.

170.7(2) *Potential sanctions.* Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

a. Special review of the provider's claims for child care assistance.

b. Suspension from receipt of child care assistance payment for six months.

c. Ineligibility to receive payment under child care assistance.

170.7(3) *Factors considered in determining level of sanction.* The department shall evaluate the following factors in determining the sanction to be imposed:

a. *History of prior violations.*

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

b. *Prior imposition of sanctions.*

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

c. *Seriousness of the violation.*

(1) If the amount fraudulently received is less than $5,000, the sanction level shall be determined according to paragraphs *"a"* and *"b."*

(2) If the amount fraudulently received is $5,000 or more, and the sanction determined according to paragraphs *"a"* and *"b"* is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is $5,000 or more, and the sanction determined according to paragraphs *"a"* and *"b"* is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

d. *Extent of the violation.*

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs *"a"* and *"b."*

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs *"a"* and *"b"* is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs *"a"* and *"b"* is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

170.7(4) *Mitigating factors.*

a. If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

(1) Prior provision of provider education.

(2) Provider willingness to obey program rules.

b. If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph *"a"* indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

(1) Suspension from receipt of child care assistance payment for six months; and

(2) A special review of provider claims.

c. If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph *"a"* indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

441—170.8(234) Allocation of funds. Rescinded IAB 2/6/02, effective 4/1/02.

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments shall be subject to recoupment.

170.9(1) *Notification and appeals.* All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—subrule 7.5(9).

170.9(2) *Determination of overpayments.* All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

170.9(3) *Benefits or payments issued pending appeal decision.* Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

170.9(4) *Failure to cooperate.* Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

170.9(5) *Payment agreement.* The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

170.9(6) *Procedures for recoupment.*

a. When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment on Form 470-4530, Notice of Child Care Assistance Overpayment.

c. When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

170.9(7) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than $35. Recoupment will be waived on nonfraud overpayments of less than $35 which have been held in suspense for three years.

[**ARC 9651B**, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 237A.13 and 237A.29.

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CHAPTER 171
ADULT DAY CARE

Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 172
FAMILY-CENTERED CHILD WELFARE SERVICES

PREAMBLE

These rules define and describe procedures for delivery of family-centered child welfare services. The rules describe the service definitions and eligibility criteria, contractor selection and contracting processes, performance measures, billing and payment methods, procedures for client appeals, and service review and audit procedures.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

DIVISION I
GENERAL PROVISIONS

441—172.1(234) Definitions.

"Agency" means the Iowa department of human services.

"Child" means a person who meets the definition of a child in Iowa Code section 234.1(2).

"Child vulnerability" means the degree that a child cannot on the child's own avoid, negate, or minimize the impact of present or impending danger.

"Conditionally safe" means that one or more signs of present or impending danger to a child that are identified on the safety assessment form are not offset by the child's degree of vulnerability or the caretaker's protective capacity. A safety plan is required.

"Contractor" means a private organization authorized to do business in Iowa that has entered into a contract with the agency to provide one or more of the services defined in this chapter. "Contractor" refers to the organization that is named as the responsible party in the contract and whose authorized representative has signed the contract.

"Family safety, risk, and permanency service" means a service that uses strategies and interventions designed to achieve safety and permanency for a child with an open agency child welfare case, regardless of the setting in which the child resides.

"Permanency" means a child has a safe, stable, custodial environment in which to grow up and a lifelong relationship with a nurturing caregiver.

"Protective capacities" means the family strengths or resources that reduce, control, or prevent risks from arising or from having an unsafe impact on a child.

"Risk" means the probability or likelihood that a child will experience maltreatment.

"Safe" means that no signs of present or impending danger to a child are identified or that one or more signs of present or impending danger are identified but the child's degree of vulnerability or the caregiver's protective capacities offset the current threat. The child is not likely to be in imminent danger of maltreatment.

"Safety plan service" means a service that is designed to monitor the safety of a child during the agency's child protective assessment or child in need of assistance assessment process.

"Service area manager" means the agency official responsible for managing the agency's programs, operations, and budget within one of the agency service areas.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—172.2(234) Purpose and scope. Family-centered child welfare services are designed to achieve safety, permanency, and well-being for children.

172.2(1) Family-centered child welfare services provide interventions and supports for children who have come to the agency's attention because of:

a. Allegations of child abuse; or

b. Juvenile court action to adjudicate the child as a child in need of assistance.

172.2(2) Family-centered child welfare services shall be designed to:

a. Identify and build on the family's strengths and enhance the family's protective capacities;

b. Address the risk factors that affect the child's safety, permanency, and well-being; and

c. Help the family become connected with community support systems in order to promote greater self-reliance.

172.2(3) Family-centered child welfare services shall utilize evidence-based interventions to the greatest possible extent.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.3(234) Authorization. When the agency has approved provision of family-centered child welfare services for a child and family, the agency worker shall notify the contractor by issuing the referral and authorization for child welfare services form. This referral form shall indicate:

1. The specific service category authorized (safety plan; family safety, risk, and permanency); and
2. The duration of the authorization.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—172.4(234) Reimbursement. Billed services that meet the requirements of this chapter and the contract between the agency and the contractor shall become a liability of the state. The format and process for submitting billings to the agency and for receiving agency payments shall be specified in all contracts. The agency shall process claims for payment promptly upon submission by the contractor.

172.4(1) The contractor shall bear ultimate responsibility for the completeness and accuracy of all billings submitted.

172.4(2) The contractor shall maintain all financial and service records that are necessary to substantiate the contractor's claims submitted for reimbursement for services provided to agency clients as specified in the contract.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.5(234) Client appeals. Clients may appeal the agency's decision pursuant to 441—Chapter 7 when:

1. The client's application for services as described in this chapter is denied, or
2. The services are terminated.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.6(234) Reviews and audits. Contractors for the services described in this chapter shall be subject to review and audit procedures established by the agency. Information on these procedures shall be included in the request for proposals and in contracts resulting from the procurement process.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.7 to **172.9** Reserved.

DIVISION II
SAFETY PLAN SERVICES

PREAMBLE

Family-centered safety plan services are designed to maintain children safely in their own families whenever possible. These services use strategies and interventions to monitor and evaluate the safety of children who, during a child protective assessment or during the agency's child in need of assistance assessment, are assessed to be conditionally safe.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.10(234) Service requirements. A contractor providing a safety plan service shall meet the following requirements:

172.10(1) The service shall meet the minimum expectations defined in the contract.

172.10(2) The contractor shall provide interventions and supports based on the particular service needs identified for each child and family.

172.10(3) The contractor shall design interventions that:

a. Promote identification and enhancement of family strengths and protective capacities;

b. Address the factors that have placed the child in "conditionally safe" status;

c. Strengthen family connections to community resources and informal supports; and

d. Are culturally competent and respectful of the family's cultural, ethnic, and racial identity and values.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.11(234) Contractor selection. Family-centered safety plan services shall be available on a statewide basis and shall be purchased through a formal competitive selection process according to the requirements of 11—Chapters 118 and 119.

172.11(1) The agency shall issue a request for proposals at the state level to seek applications from organizations interested in providing family-centered safety plan services within specific geographic areas.

172.11(2) The request for proposals shall specify:

a. The minimum qualifications and requirements for consideration as a contractor;

b. The scope of services to be purchased; and

c. The duration of contracts to be awarded.

172.11(3) The agency shall select one or more contractors within each agency service area based on service needs and the number and quality of contractor proposals.

172.11(4) When multiple contractors are selected to serve the same geographic area, the agency shall implement a fair and equitable case referral process.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.12(234) Service eligibility.

172.12(1) The agency may refer a family for family-centered safety plan services when:

a. A child in the family is alleged to be a victim of abuse (an "alleged child victim") on a child protective assessment or is the subject of a child in need of assistance assessment (a "child subject"); and

b. During the child protective assessment or child in need of assistance assessment, the agency determines that the alleged child victim or child subject is conditionally safe.

172.12(2) When the agency approves a case for safety plan services, the following persons may be included in service provision:

a. The alleged child victim or child subject;

b. Any whole, half, or step siblings of the alleged child victim or child subject who reside in the same household; and

c. The parents, stepparents, adoptive parents, or caretakers of the alleged child victim or child subject.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.13(234) Service components.

172.13(1) *Strategies and interventions.* Safety plan services shall provide a flexible array of strategies and interventions to:

a. Monitor, evaluate, and intervene to ensure the child's safety; and

b. Evaluate and supplement the protective capacities of the child's caregivers.

172.13(2) *Service activities.* The activities to be provided by safety plan services shall be as described in the scope of services section of the request for proposals and in the contract. At a minimum, a contractor for safety plan services shall do all of the following:

a. Be available 24 hours a day, seven days per week.

b. Respond to the agency worker within one hour after the contractor receives a referral call.

c. Initiate face-to-face contact with the alleged child victim or child subject and the child's parents within 24 hours of the referral call from the agency worker.

d. Make daily face-to-face contact with the alleged child victim or child subject and the child's parents as identified in the safety plan form and the safety plan services referral face sheet. The frequency of contact with siblings and others involved in the case shall be as identified on the safety plan service referral face sheet.

e. Provide an electronic communication to update the agency worker by the end of the next calendar day after each contact with a person included in service provision.

f. Attend all family team meetings held on behalf of the family during the service delivery period.

g. Respond within two hours to any family crisis during the service delivery period.

(1) The response may be made either face to face or by telephone, depending on the situation.

(2) Immediately following the response, the contractor shall report the crisis and the response to the agency worker or the worker's supervisor via telephone or electronic communication.

h. Attend court hearings about the child upon request of the court or the agency worker.

172.13(3) *Additional services available.* Based on child and family needs and subject to approval by the agency worker, a child and family who are receiving safety plan services may also receive the following services, which shall be purchased and funded separately, in addition to the activities listed in subrule 172.13(2):

a. Drug testing as provided in subrule 172.30(1).

b. Family team meeting facilitation as provided in subrule 172.30(2).

c. Legal services for permanency as provided in subrule 172.30(3).

d. Payment of foster family care maintenance costs under rule 441—156.6(234) if the child is placed in foster family care.

e. Shelter care payment as provided in 441—subrule 156.11(3) if the child is placed in shelter care.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—172.14(234) Monitoring of service delivery.

172.14(1) *Case management.* During the time a child and the child's family are approved to receive safety plan services, the agency worker shall be responsible for providing case management. The agency worker shall maintain contact with the family and the family's contractor to ensure that factors that present risks to the safety and well-being of children in the family are being adequately addressed.

172.14(2) *Contractor progress reports.* A contractor for safety plan services shall submit client reports in accordance with the requirements concerning format, content, and frequency that are specified in the contract.

172.14(3) *Outcome measures.* The agency shall establish outcome-based performance measures for safety plan services. These performance measures shall:

a. Be specified in each contract; and

b. Be aligned with the measures defined by the federal government as part of the child and family services review process.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.15(234) Billing and payment.

172.15(1) *Unit of service.* Safety plan services shall be delivered based on a 15-calendar-day unit of service with an established per-unit payment rate that shall be specified in each contract. The agency worker may purchase up to two units of service for a case.

172.15(2) *Performance-based payments.* Contracts for safety plan services may contain provisions under which a portion of the payment to the contractor is connected to the contractor's level of achievement on specified outcome-based performance measures. Any provisions for performance-based payments shall be described in the agency's request for proposals and in the contract.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.16 to **172.19** Reserved.

DIVISION III
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

PREAMBLE

Family safety, risk, and permanency services provide family-focused interventions and supports to improve parents' capacity to keep their children safe. The purpose of these services is to achieve safety and permanency for children, regardless of the setting in which the children reside. The outcome may be to maintain children safely within their own families or with relatives, to reunite children safely with their parents or other relatives, or to achieve alternative permanent family connections for the child.

441—172.20(234) Service requirements. Family safety, risk, and permanency services shall meet the following requirements:

172.20(1) The service shall meet the minimum expectations defined in the contract.

172.20(2) The contractor shall have flexibility to select interventions and supports based on the particular service needs identified for each child and family.

172.20(3) The contractor shall:

a. Identify family strengths and protective capacities;

b. Build on these strengths in the contractor's interventions with children and families;

c. Participate in family team meetings and court hearings;

d. Be culturally competent and respectful of the family's cultural, ethnic, and racial identity and values;

e. Work to connect children and families with community resources and informal support systems to promote family self-reliance;

f. Use evidence-based models of intervention to the greatest extent possible;

g. Address risk factors and needs that are barriers to the child's safety, permanency, and well-being.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.21(234) Contractor selection. Family safety, risk, and permanency services shall be available on a statewide basis and shall be purchased through a formal competitive selection process according to the requirements of 11—Chapters 118 and 119.

172.21(1) The agency shall issue a request for proposals at the state level to seek applications from organizations interested in providing family safety, risk, and permanency services within specific geographic areas.

172.21(2) The request for proposals shall specify:

a. The minimum qualifications and requirements for consideration as a contractor;

b. The scope of services to be purchased; and

c. The duration of contracts to be awarded.

172.21(3) The agency shall select one or more contractors within each agency service area based on service needs and the number and quality of contractor proposals.

172.21(4) When multiple contractors are selected to serve the same geographic area, the agency shall implement a fair and equitable case referral process.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.22(234) Service eligibility. Family safety, risk, and permanency services may be provided when the child meets the criteria in subrules 172.22(1) and 172.22(2).

172.22(1) The child is eligible for child welfare services based on:

a. The child's adjudication as a child in need of assistance; or

b. The child's placement out of home under the care and supervision of the agency; or

c. Evaluation of the findings of a child abuse assessment report and the family's risk assessment score.

172.22(2) The child is in need of services:

a. To maintain the child's placement safely within the child's own family or in the home of a relative or other suitable person; or

b. To reunify the child safely with the child's birth family or with another relative following placement with a relative or in a foster family, shelter care facility, group care facility, or other placement setting; or

c. To move the child toward an alternative permanent family connection.

172.22(3) When the agency approves a case for family safety, risk, and permanency services, the following persons may be included in service provision:

a. A child or children who are determined eligible for service under this rule;

b. Any whole, half, or step siblings of that child or children who:

(1) Reside in the same household at the time of service referral,

(2) Move into the household during the service delivery period, or

(3) Are in placement under the care and supervision of the agency; and

c. The parents, stepparents, adoptive parents, or caretakers of that child or children and any adult who has a significant relationship with that child or children.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—172.23(234) Service components.

172.23(1) *Strategies and interventions.* Family safety, risk, and permanency services shall be designed to deliver a flexible array of strategies and interventions to promote achievement of the goals of child and family safety, risk reduction, and permanency for children. It is expected that:

a. The specific interventions and supports delivered and service intensity will vary depending on child and family needs identified during the course of the family's child welfare involvement with the agency; and

b. The contractor will use evidence-based models of intervention when possible as well as develop creative and innovative service models.

172.23(2) *Service activities.* Specific minimum service standards and expectations for family safety, risk, and permanency services shall be as described in the request for proposals issued by the agency. The contractor shall be responsible for meeting identified needs of referred children and families through interventions that may include, but are not limited to, the following:

a. Assistance and instruction for parents in life skills and household management.

b. Family functioning assessment.

c. Crisis intervention response.

d. Support for a plan of family visits when children are placed out of home, and supervision of visits, if necessary.

e. Safety checks and supervision to ensure that children are safe within their environments.

f. Transportation assistance for children and families to access needed services and supports.

g. Interventions to enhance family functioning skills, which may include interventions and instruction in one or more of the following areas:

(1) Communication and social interaction skills.

(2) Family relationship enhancement.

(3) Parenting education and behavior management of children.

(4) Consumer education instruction.

(5) Advocacy skill enhancement.

(6) Transitional life skills for adolescents.

h. Activities to help connect the child and family with mental health and substance abuse services and with community resources and informal supports to promote self-reliance.

i. Activities to support the families' participation in services related to mental health, domestic violence, and substance abuse.

j. Family reunification interventions.

k. Permanency planning activities, including help in identifying and achieving alternative permanent family connections for the child.

l. Provision of tangible supports for children and families.

172.23(3) *Additional services available.* Based on child and family needs and subject to approval by the agency worker, a child and family who are receiving family safety, risk, and permanency interventions may also be approved to receive the following services, which shall be purchased and funded separately:

a. Drug testing as provided in subrule 172.30(1).

b. Family team meeting facilitation as provided in subrule 172.30(2).

c. Legal services for permanency as provided in subrule 172.30(3).

d. Foster care maintenance payments under rule 441—156.6(234) if the child is placed in foster family care.

e. Shelter care payment as provided in 441—subrule 156.11(3) if the child is placed in shelter care.

f. Group care maintenance and group care child welfare services under rule 441—156.9(234) if the child is placed in group care.

g. Supervised apartment living maintenance and services under rule 441—156.12(234) if the child is placed in supervised apartment living placement.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.24(234) Monitoring of service delivery.

172.24(1) *Case management.* During the time that a child and the child's family are approved to receive family safety, risk, and permanency services, the agency worker shall be responsible for maintaining contact with the child and family to ensure that:

a. The factors that present risks of harm to the safety and well-being of all children in the family are being adequately addressed; and

b. Services and supports are in place to achieve the child's permanency goal.

172.24(2) *Contractor progress reports.* A contractor for family safety, risk, and permanency services shall submit service progress reports in accordance with the format, content, and frequency requirements as specified in the agency's request for proposals and in the contract.

172.24(3) *Outcome measures.* The agency shall establish outcome-based performance measures for family safety, risk, and permanency services. These performance measures shall:

a. Be specified in each contract; and

b. Be aligned with the measures defined by the federal government as part of the child and family services review process.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.25(234) Billing and payment.

172.25(1) *Unit of service.* Family safety, risk, and permanency services shall be purchased based on a calendar month as one unit of service.

a. A monthly payment rate shall be established for each contract.

b. When services are opened or closed with agency worker approval during a calendar month, payment shall be prorated based on the number of days the case was approved for services during the month, including both the beginning and ending dates of service. The amount paid for each day of service shall be the contractor's monthly rate divided by 30.

172.25(2) *Performance-based payments.* Contracts for family safety, risk, and permanency services may contain provisions under which a portion of the contractor's payment is connected to the contractor's level of outcome-based performance achievement. Any performance-based payment provisions and procedures shall be described in the agency's request for proposals and in each contract.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.26 to **172.29** Reserved.

DIVISION IV
FAMILY-CENTERED SUPPORTIVE SERVICES

PREAMBLE

Family-centered supportive child welfare services are specific services that agency workers may approve and deliver at various points during the course of a child's and family's involvement with the agency's child welfare system to address the children's safety, permanency, and well-being.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.30(234) Service components. Family-centered supportive services include the following components:

172.30(1) *Drug testing.* At a minimum, drug testing contractors shall be responsible for the costs associated with all of the following activities:

a. Collection of samples from adults or children or installation of sweat patches or other drug-testing devices;

b. Purchasing of collection supplies and devices;

c. Preservation and documentation of the chain of evidence for collected samples;

d. Laboratory testing and analysis fees;

e. Reporting of test results to the referring worker; and

f. Provision of court testimony, if requested, concerning testing results.

172.30(2) *Family team meeting facilitation.* Meeting facilitation shall:

a. Be provided in accordance with the agency's family team meeting model of practice and family team meeting standards; and

b. Include activities involved in:

(1) Planning, preparing for, arranging, facilitating, and reporting on a family team meeting for a child welfare case; and

(2) Coaching and mentoring new facilitators.

172.30(3) *Legal services for permanency.* Payment for legal services shall include:

a. Providing funding to an attorney for legal services associated with achieving greater permanency for children through either:

(1) Modification of a child custody order; or

(2) Creation of a guardianship or adoptive relationship for a child who is residing with a relative or another suitable caretaker; and

b. Payment of related legal fees, such as filing costs and reporting fees.

172.30(4) *Service-area-specific services.* A service area manager shall have the authority to use a portion of the child welfare funds allocated to that service area to fund family-centered services specific to that agency service area. Service-area-specific services shall be designed to:

a. Address unique child welfare needs within the service area;

b. Allow flexibility and innovation in intervention approach; and

c. Promote safety, permanency, and well-being for children.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.31(234) Contractor selection. With the exception of legal services for permanency, family-centered supportive services shall be purchased through a formal competitive selection process according to the requirements of 11—Chapters 118 and 119. With the exception of service-area-specific services, family-centered supportive services shall be available on a statewide basis.

172.31(1) The agency shall procure family-centered supportive services within specific geographic areas.

172.31(2) The request for proposals shall specify:

a. The minimum qualifications and requirements for consideration as a contractor;

b. The scope of services to be purchased;

c. The specific geographic areas to be covered; and

d. The duration of contracts to be awarded.

172.31(3) The agency shall select one or more contractors within each geographic area based on service needs and the number and quality of contractor proposals.

172.31(4) When multiple contractors are selected to serve the same geographic area, the agency shall implement a fair and equitable case referral process.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.32(234) Service eligibility. Supportive child welfare services are designed to provide services for children when:

1. The agency has initiated a child protective assessment in response to receipt of child abuse allegations concerning the child or another child within the same family; or
2. The agency has assumed care and supervision of a child placed in out-of-home care; or
3. The agency has opened a child welfare service case on the child or family following a child abuse assessment or juvenile court action; or
4. A child in need of assistance petition has been filed on behalf of the child and the court has set a date for the prehearing conference or adjudication hearing.

[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.33(234) Monitoring of service delivery.

172.33(1) *Case management.* When the agency approves a child and family to receive one or more family-centered supportive service components, the child's agency worker shall be responsible for providing case management. Case management shall include maintaining contact with the child, the family, and the contractor to ensure that approved services:

a. Are delivered in a manner that will be most effective; and

b. Are helping to achieve identified goals and objectives.

172.33(2) *Contractor progress reports.* The agency shall establish and define mandated contractor reporting requirements for each family-centered supportive service component and include these requirements in the agency's request for proposals and contracts developed as a result of the procurement process.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

441—172.34(234) Billing and payment. The units of service for family-centered supportive service components shall be as follows:

172.34(1) *Drug testing.* The unit of service for drug testing shall be completion of one drug testing procedure, as defined in the agency's request for proposals.

172.34(2) *Family team meeting facilitation.*

a. Family team meeting facilitation shall be purchased based on either:

(1) A payment rate for each facilitated family team meeting; or

(2) A monthly payment to a contractor to facilitate family team meetings.

b. Regardless of the purchasing method, facilitation services shall include:

(1) Completion of necessary premeeting planning activities;

(2) Facilitation of the meeting; and

(3) Completion of a written report of meeting results.

172.34(3) *Legal services for permanency.* The unit of service for legal services shall be a variable amount per client, based on the actual costs of legal services and related court costs necessary to achieve the desired legal result, up to the limits applicable to nonrecurring expenses for adoption subsidy as described in 441—subparagraph 201.6(1)*"a"*(7).

172.34(4) *Service-area-specific services.* The unit of services and unit cost for service-area-specific services shall be defined in the request for proposals and contracts resulting from the procurement process.
[**ARC 9491B**, IAB 5/4/11, effective 7/1/11]

These rules are intended to implement Iowa Code section 234.6.

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[Prior to 7/1/83, Social Services[770] Ch 140]
[Previously appeared as Ch 140—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

CHAPTER 173
FAMILY PLANNING SERVICES

[Prior to 7/1/83, Social Services[770] Ch 140]
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[Prior to 2/11/87, Human Services[498]]

Rescinded IAB 8/1/07, effective 9/5/07

CHAPTER 174
TRANSPORTATION SERVICES

Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 175
ABUSE OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 135]
[Previously appeared as Ch 135—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
CHILD ABUSE

[Rescinded IAB 5/6/98, effective 9/1/98]

441—175.1 to **175.20** Reserved.

DIVISION II
CHILD ABUSE ASSESSMENT

PREAMBLE

The purpose of this division is to implement requirements established in the Iowa Code which charge the department of human services with accepting reports of child abuse, assessing those reports and taking necessary steps to ensure a reported child's safety. Protection is provided through encouraging the reporting of suspected cases of abuse, conducting a thorough and prompt assessment of the reports, and providing rehabilitative services to abused children and their families. This response to reports of child abuse emphasizes child safety and engagement of a family in services, where necessary. The assessment-based approach recognizes that child protection and strong families are the responsibility not only of the family itself, but also of the larger community (including formal and informal service networks). It is the department's legal mandate to respond to reports of child abuse. The assessment approach shall allow the department to develop divergent strategies when responding to reports of child abuse, adjusting its response according to the severity of abuse, to the functioning of the family, and to the resources available within the child and family's community.

441—175.21(232,235A) Definitions.

"Adequate food, shelter, clothing, medical or mental health treatment, supervision or other care" means that food, shelter, clothing, medical or mental health treatment, supervision or other care which, if not provided, would constitute a denial of critical care.

"Allegation" means a statement setting forth a condition or circumstance yet to be proven.

"Assessment" means the process by which the department responds to all accepted reports of alleged child abuse. An "assessment" addresses child safety, family functioning, culturally competent practice, and identifies the family strengths and needs, and engages the family in services if needed. The department's assessment process occurs either through a child abuse assessment or a family assessment.

"Assessment intake" means the process by which the department receives and records a report of suspected child abuse.

"Caretaker" means a person responsible for the care of a child as defined in Iowa Code section 232.68.

"Case" means a report of suspected child abuse that has been accepted for assessment services.

"Child abuse assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(1) through (3) and (5) through (10); or which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) that also allege imminent danger, death, or injury to a child. A "child abuse assessment" results in a disposition and a determination of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the registry are met.

"Community care," as provided in rule 441—186.1(234), means child- and family-focused services and supports provided to families referred from the department. Services shall be geared toward keeping the children in the family safe from abuse and neglect; keeping the family intact; preventing the need for further intervention by the department, including removal of the child from the home; and building

ongoing linkages to community-based resources that improve the safety, health, stability, and well-being of families served.

"Denial of critical care" means the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, medical or mental health treatment, supervision or other care necessary for the child's health and welfare when financially able to do so, or when offered financial or other reasonable means to do so, and shall mean any of the following:

1. Failure to provide adequate food and nutrition to the extent that there is danger of the child suffering injury or death.
2. Failure to provide adequate shelter to the extent that there is danger of the child suffering injury or death.
3. Failure to provide adequate clothing to the extent that there is danger of the child suffering injury or death.
4. Failure to provide adequate health care to the extent that there is danger of the child suffering injury or death. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child and shall not be placed on the child abuse registry. However, a court may order that medical service be provided where the child's health requires it.
5. Failure to provide the mental health care necessary to adequately treat an observable and substantial impairment in the child's ability to function.
6. Gross failure to meet the emotional needs of the child necessary for normal development.
7. Failure to provide for the adequate supervision of the child that a reasonable and prudent person would provide under similar facts and circumstances when the failure results in direct harm or creates a risk of harm to the child.
8. Failure to respond to the infant's life-threatening conditions (also known as withholding medically indicated treatment) by providing treatment (including appropriate nutrition, hydration and medication) which in the treating physician's reasonable medical judgment will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply: the infant is chronically and irreversibly comatose; the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

"Department" means the department of human services.

"Differential response" means an assessment system in which there are two discrete pathways to respond to accepted reports of child abuse, a child abuse assessment and a family assessment. The child abuse assessment pathway shall require a determination of abuse and a determination of whether criteria for placement on the central abuse registry are met.

"Facility providing care to a child" means any public or private facility, including an institution, hospital, health care facility, intermediate care facility for persons with an intellectual disability, residential care facility for persons with an intellectual disability, or skilled nursing facility, group home, mental health facility, residential treatment facility, shelter care facility, detention facility, or child care facility which includes licensed day care centers, all registered family and group day care homes and licensed family foster homes. A public or private school is not a facility providing care to a child, unless it provides overnight care. Public facilities which are operated by the department of human services are assessed by the department of inspections and appeals.

"Family assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4), but do not allege imminent danger, death, or injury to a child. A "family assessment" does not include a determination of whether a case meets the definition of child abuse and does not include a determination of whether criteria for placement on the central abuse registry are met.

"Illegal drug" means cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, including marijuana, or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

"Immediate threat" or *"imminent danger"* means conditions which, if no response were made, would be more likely than not to result in sexual abuse, injury or death to a child.

"Infant," as used in the definition of "denial of critical care," numbered paragraph "8," means an infant less than one year of age or an infant older than one year of age who has been hospitalized continuously since birth, who was born extremely prematurely, or who has a long-term disability.

"Nonaccidental physical injury" means an injury which was the natural and probable result of a caretaker's actions which the caretaker could have reasonably foreseen, or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury.

"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 which results in the death of the person who has sustained the damage.

"Preponderance of evidence" means evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

"Proper supervision" means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall the person place a child in a situation that may endanger the child's life or health, or cruelly or unduly confine the child. Dangerous operation of a motor vehicle is a failure to provide proper supervision when the person responsible for the care of a child is driving recklessly, or driving while intoxicated with the child in the motor vehicle. The failure to restrain a child in a motor vehicle does not, by itself, constitute a cause to assess a child abuse report.

"Rejected intake" means a report of suspected child abuse that has not been accepted for assessment.

"Reporter" means the person making a verbal or written statement to the department, alleging child abuse.

"Report of suspected child abuse" means a verbal or written statement made to the department by a person who suspects that child abuse has occurred.

"Subject of a report of child abuse" means any of the following:

1. A child named in a report as having been abused, or the child's attorney or guardian ad litem.
2. A parent or the attorney for the parent of a child named in a child abuse assessment summary as having been abused.
3. A guardian or legal custodian, or that person's attorney, of a child named in a child abuse assessment summary as having been abused.
4. A person or the attorney for the person named in a child abuse assessment summary as having abused a child.

"Unduly" shall mean improper or unjust, or excessive.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.22(232) Receipt of a report of suspected child abuse. Reports of suspected child abuse shall be received by local department offices, the central abuse registry, or the Child Abuse Hotline.

175.22(1) Any report made to the department which alleges child abuse as defined in Iowa Code section 232.68 shall be accepted for assessment.

175.22(2) Reports of suspected child abuse which do not meet the legal definition of child abuse shall become rejected intakes.

a. If a report of suspected child abuse does not meet the legal definition of child abuse or is accepted as a family assessment, but a criminal act harming a child is alleged, the department shall immediately refer the matter to the appropriate law enforcement agency.

b. If a report constitutes an allegation of child sexual abuse as defined under Iowa Code section 232.68(2)*"c,"* except that the suspected abuse resulted from the acts or omissions of a person who was

not a caretaker, the department shall refer the report to law enforcement orally and, as soon as practicable, follow up in writing within 72 hours of receiving the report.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.23(232) Sources of report of suspected child abuse.

175.23(1) *Mandatory reporters.* Any person meeting the criteria of a mandatory reporter is required to make an oral report of the suspected child abuse to the department within 24 hours of becoming aware of the abusive incident and make a written report to the department within 48 hours following the oral report. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

175.23(2) *Others required to report.* In addition to mandatory reporters which are so designated by the Iowa Code, there are other classifications of persons who are required, either by administrative rule or department policy, to report suspected child abuse when this is a duty identified through the person's employment. Others required to report include:

a. Income maintenance workers.

b. Certified adoption investigators.

175.23(3) *Permissive reporters.* Any person who suspects child abuse may make an oral or written report, or both, to the department. Mandatory reporters may report as permissive reporters when they suspect abuse of a child outside the scope of their professions. A permissive reporter may remain anonymous and is not required by law to report abuse.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.24(232) Assessment intake process. The primary purpose of intake is to obtain available and pertinent information regarding an allegation of child abuse and determine whether a report of suspected child abuse becomes accepted for assessment or a rejected intake.

175.24(1) To result in an assessment, the report of suspected child abuse must include some information to indicate all of the following.

a. The alleged victim of child abuse is a child.

b. The alleged perpetrator of child abuse is a caretaker.

c. The alleged incident falls within the definition of child abuse.

175.24(2) If the report constitutes a child abuse allegation, a determination is made as to whether the assessment will be assigned as a child abuse assessment, to be commenced within 24 hours of receiving the report, or a family assessment, to be commenced within 72 hours of receiving the report.

a. A child abuse assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(1) through (3) and (5) through (10); or which allege child abuse as defined in Iowa Code section 232.68(4) that also allege imminent danger, death, or injury to a child. If one or more of the following factors are met, a child abuse assessment shall be required:

(1) The alleged abuse type includes a category other than denial of critical care.

(2) The allegation requires a one-hour response or alleges imminent danger, death, or injury to a child.

(3) The child has been taken into protective custody as a result of the allegation.

(4) There is an open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is not a birth or adoptive parent, a legal guardian, or a member of the child's household.

(6) There has been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is failure to thrive or that the caretaker has failed to respond to an infant's life-threatening condition.

(10) The allegation involves an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

b. A family assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) but do not allege imminent danger, death, or injury to a child. If all of the following factors are met, a family assessment shall be required:

(1) The alleged abuse type is denial of critical care only.

(2) The allegation does not require a one-hour response or allege imminent danger, death, or injury to a child.

(3) The child has not been taken into protective custody as a result of the allegation.

(4) There is no current open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is a birth or adoptive parent, a legal guardian, or a member of the child's household.

(6) There has not been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been no prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is not alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is not failure to thrive or that the caretaker has failed to respond to an infant's life-threatening condition.

(10) The allegation does not involve an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

175.24(3) Only the person making a report of suspected abuse may be contacted during the intake process to expand upon or to clarify information in the report. Any contact with subjects of the report or with anyone outside the department of human services, other than the original reporter(s), automatically causes the report of suspected child abuse to be accepted for assessment.

175.24(4) When it is determined that the report of suspected child abuse fails to constitute an allegation of child abuse, the report of suspected child abuse shall become a rejected intake. Rejected intake information shall be maintained by the department for three years from the date the report was rejected and shall then be destroyed.

175.24(5) The county attorney shall be notified of all reports of suspected child abuse. When a report of suspected child abuse is received which does not meet the requirements for an assessment or is accepted as a family assessment, and there is information about a criminal act harming a child, the department shall notify law enforcement of the report.

175.24(6) When it is determined that a report of a child needing the assistance of the court fails to meet the definition of "child in need of assistance" in Iowa Code section 232.2(6), the report shall become a rejected child in need of assistance intake. The department shall maintain the report for three years from the date the report was rejected and shall then destroy it.

[**ARC 8453B**, IAB 1/13/10, effective 3/1/10; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.25(232) Assessment process. A child abuse assessment shall be initiated within 24 hours following the report of suspected child abuse. A family assessment shall be initiated within 72 hours following the report of suspected child abuse. The primary purpose in conducting an assessment is to protect the safety of the child named in the report. The secondary purpose of the assessment is to engage the child's family in services in a culturally competent way, to enhance family strengths and to address needs, where this is necessary and desired.

175.25(1) *Observing and evaluating the child's safety.* A safety assessment and risk assessment will be completed during the course of a child abuse assessment or family assessment.

a. During a child abuse assessment, when there is an immediate threat to the child's safety, reasonable efforts shall be made to observe the alleged child victim and evaluate the safety of the child named in the report within one hour of receipt of the report of suspected child abuse. Otherwise,

reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 24 hours of receipt of the report of suspected child abuse.

(1) When the alleged perpetrator clearly does not have access to the alleged child victim, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 96 hours of receipt of the report of suspected child abuse.

(2) When reasonable efforts have been made to observe the alleged child victim within the specified time frames and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

b. During a family assessment, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 72 hours of receipt of the report of suspected child abuse.

(1) When reasonable efforts have been made to observe the alleged child victim within the specified time frame and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

(2) If at any time during a family assessment a child is determined unsafe or in imminent danger, it appears that the immediate safety or well-being of a child is endangered, it appears that the family may flee or the child may disappear, or that the facts otherwise warrant, the department shall immediately commence a child abuse assessment as defined in Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590.

(3) If the department determines that safety issues continue to require a child to reside outside of the child's home at the conclusion of a family assessment, the department shall transfer the assessment to the child abuse assessment pathway for a disposition.

175.25(2) *Interviewing the alleged child victim.* The primary purpose of an interview with the child, during the course of a child abuse assessment or family assessment, is to gather information regarding the abuse allegation, the child's immediate safety, and risk of abuse. During a child abuse assessment, the child protection worker shall also identify the person or persons responsible for the alleged abuse as well as the nature, extent, and cause of injuries, if any, to the child named in the report of suspected child abuse.

175.25(3) *Interviewing subjects of the report and other sources.*

a. During a child abuse assessment, attempts shall be made to conduct interviews with subjects of the report and persons who have relevant information to share regarding the allegations. This may include contact with physicians to assess the child's condition. The child's custodial parents or guardians and the alleged perpetrator (if different) shall be interviewed or offered the opportunity to be interviewed. The court may waive the requirement of the interview for good cause.

b. During a family assessment, the child's custodial parents or guardians shall be interviewed or offered the opportunity to be interviewed. The child protection worker may request information from any person believed to have knowledge regarding a child named in an assessment. A family assessment requires the cooperation of the family; should a family choose not to participate, the department is required to transfer the assessment to the child abuse assessment pathway for a disposition.

175.25(4) *Gathering of physical and documentary evidence.* During a child abuse assessment, evidence shall be gathered from, but not be limited to, interviews, observations, photographs, medical and psychological reports and records, reports from child protection centers, written reports, audiotapes and their transcripts or summaries, videotapes and their transcripts or summaries, or other electronic forms.

175.25(5) *Evaluating the home environment and relationships of household members.* An evaluation of the home environment shall be conducted during the course of an assessment with the consent of the parent or guardian. If permission is refused, the juvenile court may authorize the worker to enter the home to observe or interview the child.

a. If protective concerns are identified, the child protection worker shall evaluate the child named in the report and any other children in the same home as the parents or other persons responsible for their care.

(1) Each assessment shall include a full description of observations and information gathered during the assessment process. This description shall provide information which evaluates the safety of the child named in the report.

(2) If the child protection worker has concerns about a child's safety or a family's functioning, the worker shall conduct a more intensive assessment until those concerns are addressed.

b. When an assessment is conducted at an out-of-home setting, an evaluation of the environment and relationships where the abuse allegedly occurred shall be conducted.

c. The child abuse assessment shall include a description of the name, age, and condition of other children in the same home as the child named in the report.

175.25(6) *Evaluating the information.* During a child abuse assessment, evaluation of information shall include an analysis, which considers the credibility of the physical evidence, observations, and interviews, and shall result in a conclusion of whether or not to confirm the report of suspected child abuse.

175.25(7) *Determining placement on central abuse registry.* During a child abuse assessment, a determination of whether the report data and disposition data of a confirmed case of child abuse is subject to placement on the central abuse registry pursuant to Iowa Code section 232.71D shall be made on each assessment. Determining placement on the central abuse registry is not applicable in a family assessment.

175.25(8) *Service recommendations and referrals.* During or at the conclusion of a child abuse assessment or a family assessment, the department shall consult with the child's family to offer services to the child and the child's family which address strengths and needs identified in the assessment. The department may recommend information, information and referral, community care referral, or services provided by the department. If it is believed that services are necessary for the protection of the abused child or other children in the home, juvenile court intervention shall be sought.

a. Information or information and referral.

(1) Either information or information and referral shall be offered when:

1. A family assessment has identified the child to be at low risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at low risk of future abuse or neglect; or

3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at low risk of future abuse or neglect.

(2) Recommendation options for information and information and referral.

1. When no service needs are identified, the worker may recommend no service; or

2. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through informal supports; or

3. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through community organizations.

b. Referral to community care.

(1) A referral to community care shall be offered when:

1. A family assessment has identified the child to be at moderate or high risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at moderate or high risk of future abuse or neglect; or

3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at moderate risk of future abuse or neglect.

(2) Referral to community care not offered. A referral to community care shall not be offered when any child in the family has an open child welfare service case with the department, a child in need of assistance petition was filed or is pending, or if the abuse occurred in an out-of-home setting.

(3) Responsibilities for community care referral.

1. At the conclusion of a family assessment, the department shall transfer the case, if appropriate, to a contracted provider to review the service plan for the child and family.

2. The contracted provider shall make a referral to the department abuse hotline if a family's noncompliance with a service plan places a child at risk.

- If any of the criteria for child abuse as defined in Iowa Code section 232.68 are met, the department shall commence a child abuse assessment.
- If criteria for a child in need of assistance as defined in Iowa Code section 232.2(6) are met, the department shall determine whether to request a child in need of assistance petition.

c. Referral for department services.

(1) The department shall provide or arrange for and monitor services for abused children and their families on a voluntary basis or under a final or intermediate order of the juvenile court when:

1. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at high risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is founded.

(2) The worker shall recommend new or continuing services to the family to be provided by the department, either directly or through contracted agencies.

(3) Families that refuse voluntary services shall be referred for a child in need of assistance petition through juvenile court.

175.25(9) *Court action following assessment.* If, upon completion of an assessment performed under Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590, the department determines that the best interests of the child require juvenile court action, the department shall act appropriately to initiate the action.

a. If at any time during the assessment process the department believes court action is necessary to safeguard a child, the department shall act appropriately to initiate the action.

b. The department shall assist the juvenile court or district court during all stages of court proceedings involving an alleged child abuse case in accordance with Iowa Code section 232.71C as amended by 2013 Iowa Acts, House File 590.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.26(232) Completion of a written assessment report. The child protection worker shall complete a written assessment report as follows:

175.26(1) *Completion of a child abuse assessment report.* A child abuse assessment report shall be completed within 20 business days of the receipt of the child abuse report. In most instances, a child abuse assessment report shall be developed in conjunction with the child and family being assessed. A child abuse assessment report shall consist of two parts as follows:

a. Report and disposition data. A child abuse assessment report shall include report and disposition data as follows:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously investigated or assessed. If the report of suspected child abuse was initially accepted as a family assessment, the reason why it was transferred to a child abuse assessment shall be identified.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Findings and contacts: a description of the child's condition including identification of the nature, extent, and cause of the injuries, if any, to the child named in the report; identification of the injury or risk to which the child was exposed; the circumstances which led to the injury or risk to the child; the identity of the person alleged to be responsible for the injury or risk to the child; an evaluation of the home environment; the name and condition of other children in the same home as the child named in the report if protective concerns are identified; a list of collateral contacts; and a history of confirmed or founded abuse.

(4) Determination regarding the allegations of child abuse: a statement of determination of whether the allegation of child abuse was founded, confirmed but not placed on the central abuse registry, or not

confirmed. The statement shall include a rationale for placing or not placing the report on the central abuse registry.

(5) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

(6) Juvenile court recommendation: a statement describing whether juvenile court action is necessary to ensure the safety of the child; the type of action needed, if any; and the rationale for the recommendation.

(7) Criminal court recommendation: a statement describing whether criminal court action is necessary and the rationale for the recommendation.

(8) Addendum: An addendum to a child abuse assessment report shall be completed within 20 business days when any of the following occur:

1. New information becomes available that would alter the finding, conclusion, or recommendation of the report.

2. Substantive information that supports the finding becomes available.

3. A subject who was not previously interviewed requests an interview to address the allegations of the report.

4. A review or a final appeal decision modifies the report.

b. Use of assessment data. A safety assessment, family risk assessment, and safety plan, if applicable, may be used as part of the child's initial case plan, referenced at 441—subrule 130.7(3), for cases in which the department will provide services.

175.26(2) *Completion of a family assessment report.* A family assessment report shall be completed within ten business days of the receipt of the report of suspected child abuse. A family assessment report shall consist of assessment data only.

a. Assessment data. A family assessment report shall include information pertaining to the department's evaluation of a family, which includes:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously assessed.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Contacts: description of the circumstances that led to the allegations of abuse; strengths and needs of the child, and of the child's parent, home, and family; any information obtained from others during the assessment; a history of confirmed or founded abuse; and an evaluation of the home environment and evaluation of any other children in the same home as the parents or other persons responsible for the children's care.

(4) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

b. *Use of assessment data.* A safety assessment, family risk assessment, and safety plan may be used as part of the information referred for any services in which the family voluntarily agrees to participate.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.27(232) Contact with juvenile court or the county attorney. The child protection worker may orally contact juvenile court or the county attorney, or both, as circumstances warrant.

175.27(1) *Report of intake.* When a report of suspected child abuse is accepted or rejected for assessment, the county attorney shall be provided a child protective service intake form, with information about the allegation of child abuse and with identifying information about the subjects of the report.

175.27(2) *Report of disposition.* The child protection worker shall provide the juvenile court and the county attorney with a copy of the child abuse assessment report, which pertains to the findings, determinations, and recommendations regarding the child abuse assessment.

175.27(3) *Report of assessment.* The child protection worker shall provide the county attorney and the juvenile court with a copy of the family risk assessment, safety assessment, safety plan, and family assessment report when any of the following occur:

a. *County attorney's or juvenile court's assistance necessary.* The worker requires the court's or the county attorney's assistance to complete the assessment process.

b. *Court's protection needed.* The worker believes that the child requires the court's protection.

c. *Child adjudicated.* The child is currently adjudicated or pending adjudication under a child in need of assistance petition or a delinquency petition.

d. *County attorney or juvenile court requests copy.* The county attorney or juvenile court requests a copy of the child abuse assessment data. The child protection worker shall document when the assessment data is provided to the county attorney or juvenile court and the rationale provided for the request.
[**ARC 8453B**, IAB 1/13/10, effective 3/1/10; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.28(232) Consultation with health practitioners or mental health professionals. The child protection worker may contact a health practitioner or a mental health professional as circumstances warrant and shall contact a health practitioner or a mental health professional when the worker requires the assistance of the health practitioner or mental health professional in order to complete the assessment process or when the worker requires the opinion or advice of the health practitioner or mental health professional in order to determine if the child requires or should have required medical, health or mental health care as a result of suspected abuse.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.29(232) Consultation with law enforcement.

175.29(1) During the course of a child abuse assessment, the child protection worker may contact law enforcement as warranted and shall contact law enforcement when the worker believes that:

a. The abuse reported may require a criminal investigation and subsequent prosecution.

b. The child must be separated from the person responsible for the abuse.

c. Contact by the child protection worker with the family will result in a volatile and dangerous response by the child or family members.

175.29(2) During the course of a family assessment, the child protection worker shall not involve law enforcement for the purposes of a joint investigation, but shall immediately refer any information regarding a criminal act harming a child to the appropriate law enforcement agency.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.30(232) Information shared with law enforcement. When the department is jointly conducting a child abuse assessment with law enforcement personnel, the department may share information gathered during the child abuse assessment process when an assessment is conducted in conjunction with a criminal investigation. When the department has rejected an intake or an intake

is accepted for a family assessment, only the information collected at intake (excluding reporter information) may be shared with law enforcement.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.31(232) Completion of required correspondence.

175.31(1) *Notification to parents that an assessment is being conducted.* Written notice shall be provided to the parents of a child who is the subject of an assessment within five working days of commencing an assessment. Both custodial and noncustodial parents shall be notified, if their whereabouts are known. If it is believed that notification will result in danger to the child or others, an emergency order to prohibit parental notification shall be sought from juvenile court.

175.31(2) *Notification of completion of assessment and right to request correction.* Written notice which indicates that the child abuse assessment is completed shall be provided to all subjects of a child abuse assessment and to the mandatory reporter who made the report of child abuse. Both custodial and noncustodial parents shall be notified if their whereabouts are known.

a. The notice shall contain the following information pursuant to Iowa Code section 235A.19:

(1) A subject may request correction of the information contained within the child abuse assessment report if the subject disagrees with the information.

(2) A person named responsible for the abuse has the right to appeal if the department does not correct the data or findings as requested.

(3) A subject, other than the person named responsible for the abuse, has the opportunity to file a motion to intervene in an appeal hearing.

b. If the child abuse assessment results in a determination that abuse is confirmed, the notice shall indicate the type of abuse, name of the child and name of the person responsible for the abuse and whether the report has been placed on the central abuse registry.

c. The department shall provide written notice to the parent or guardian of each child listed in the family assessment report of the completion of the assessment and review any service recommendations. Because no determination concerning child abuse or neglect is made and nothing is reported to the central abuse registry, a subject of a family assessment shall not be afforded the opportunity for a contested case hearing pursuant to Iowa Code chapter 17A.
[**ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.32(232,235A) Case records. The assessment case record shall contain the assessment report as described in rule 441—175.26(232) and any related correspondence or information which pertains to the assessment or to the child and family. The name of the person who made the report of child abuse shall not be disclosed.

175.32(1) *Child abuse assessment report.* A child abuse assessment report has two parts.

a. Report and disposition data as described in 175.26(1)*"a."* Subjects of the report have access to report and disposition data, including, where applicable, confirmation of placement on the central abuse registry for abuse reports meeting the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590. A child abuse assessment report shall be submitted to the central abuse registry only if the abuse is confirmed and determined to meet the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590.

b. Assessment data as described in 175.26(1)*"b"* shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(2) *Family assessment report.* A family assessment report includes assessment data only as described in 175.26(2)*"b."* Assessment data shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian of a child named in a family assessment report approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(3) *Child abuse assessments where abuse was confirmed but not placed on the central abuse registry.* The following conditions apply to case records for assessments in which abuse was confirmed but not placed on the central registry.

a. Access to the report data and disposition data is authorized only to the subjects of the report, the child protection worker, the law enforcement officer responsible for assisting in the assessment or for the temporary emergency removal of a child from the child's home, the multidisciplinary team assisting the department in the assessment of the abuse, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department or contract personnel necessary for official duties, the department of justice, and the attorney for the department.

b. The child abuse assessment is retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(4) *Child abuse assessments not placed on the central abuse registry where abuse was not confirmed.* The following conditions apply to case records for assessments in which abuse was not confirmed and not placed on the central registry:

a. Access to the assessment data on a child abuse assessment summary where abuse was not determined to have occurred and, therefore, the assessment was not placed on the central abuse registry is authorized only to the subjects of the assessment, the child protection worker, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(5) *Family assessment.* The following conditions apply to case records for all family assessments:

a. Access to the assessment data on a family assessment report is authorized only to the subjects of the assessment, the child protection worker, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The family assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.33(232,235A) Child protection centers. The department may contract with designated child protection centers for assistance in conducting child abuse assessments. When a child who is the subject of an assessment is interviewed by staff at a child protection center, that interview may be used in conjunction with an interview conducted by the child protection worker. Written reports developed by the child protection center shall be provided to the child protection worker and may be included in the assessment case record. Video or audio records are considered to be part of the assessment process and shall be maintained by the child protection center under the same confidentiality provisions of Iowa

Code section 217.30 and 441—Chapter 9. Services or assistance from a child protection center will not be available through a family assessment. Law enforcement may refer families as appropriate.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.34(232) Department-operated facilities. When an allegation of child abuse occurs at a department-operated facility, the allegation shall be referred to the department of inspections and appeals for investigation or assessment.

441—175.35(232,235A) Jurisdiction of assessments. Child protection workers serving the county in which the child's home is located have primary responsibility for completing the assessment except when the suspected abuse occurs in an out-of-home placement. Circumstances in which the department shall conduct an assessment when another state is involved include the following:

175.35(1) *Child resides in Iowa but incident occurred in another state.* When the child who is the subject of a report of suspected abuse physically resides in Iowa but has allegedly been abused in another state, the worker shall do all of the following:

a. Obtain available information from the reporter.

b. Make an oral report to the office of the other state's protective services agency and request assistance from the other state in completing the assessment.

c. Complete the assessment with assistance, as available, of the other state.

175.35(2) *Child resides in another state, but is present within Iowa.* When the child who is the subject of a report of abuse is a legal resident of another state, but is present within Iowa, the worker receiving the report shall do all of the following:

a. Act to ensure the safety of the child.

b. Contact the child's state of legal residency to coordinate the assessment of the report.

c. Commence an assessment if the state of legal residency declines to conduct an investigation.

175.35(3) *Child resides in another state and perpetrator resides in Iowa.* When the child who is the subject of a report of abuse resides in another state and the perpetrator resides in Iowa, the worker receiving the report shall do all of the following:

a. Contact the state where the child resides and offer assistance to that state in its completion of a child abuse assessment. This assistance shall include an offer to interview the person allegedly responsible for the abuse and any other relevant source of information.

b. Commence an assessment if the child's state of legal residency declines to conduct an investigation.
[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.36(235A) Multidisciplinary teams. Multidisciplinary teams shall be developed in county or multicounty areas in which more than 50 child abuse cases are received annually. These teams may be used as an advisory group to assist the department in conducting child abuse assessments. Multidisciplinary teams consist of professionals practicing in the disciplines of medicine, public health, mental health, social work, child development, education, law, juvenile probation, law enforcement, nursing, and substance abuse counseling. Members of multidisciplinary teams shall maintain confidentiality of cases in which they provide consultation. Rejected intakes shall not be shared with multidisciplinary teams since the rejected intakes are not considered to be child abuse information. During the course of a child abuse assessment, information regarding the initial report of child abuse and information related to the child and family functioning may be shared with the multidisciplinary team. After a conclusion is made, only report data and disposition data on confirmed cases of child abuse may be shared with the team members. When the multidisciplinary team is created, all team members shall execute an agreement, filed with the central abuse registry, which specifies:

175.36(1) *Consultation.* The team shall be consulted solely for the purpose of assisting the department in the child abuse assessment and diagnosis of child abuse cases.

175.36(2) *Redissemination.* No team member shall redisseminate child abuse information obtained through the multidisciplinary team. This shall not preclude redissemination of information as authorized

by Iowa Code section 235A.17 when an individual team member has received information as a result of another authorized access provision of the Iowa Code.

175.36(3) *Department not bound.* The department shall consider the recommendation of the team in a specific child abuse case but shall not, in any way, be bound by the recommendation.

175.36(4) *Confidentiality provisions.* Any written report or document produced by the team pertaining to an assessment case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of 441—Chapter 9, unless the child abuse assessment results in placement on the central abuse registry in which case the written report or document shall be subject to all confidentiality provisions of Iowa Code chapter 235A.

175.36(5) *Written records.* Any written records maintained by the team which identify an individual child abuse assessment case shall be destroyed when the agreement lapses.

175.36(6) *Compensation.* Consultation team members shall serve without compensation.

175.36(7) *Withdrawal from contract.* Any party to the agreement may withdraw with or without cause upon the giving of 30 days' notice.

175.36(8) *Expiration date.* The date on which the agreement will expire shall be included.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.37(232) Community education. The department shall conduct a continuing publicity and educational program for the personnel of the department, mandatory reporters, and the general public to encourage recognition and reporting of child abuse, to improve the quality of reports of child abuse made to the department, and to inform the community about the assessment-based approach to child abuse cases.

441—175.38(235) Written authorizations. Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on the authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.39(232) Founded child abuse. Reports of child abuse where abuse has been confirmed shall be placed on the central abuse registry as founded child abuse for either five or ten years under any of the circumstances specified by Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590. When none of the placement criteria listed in Iowa Code section 232.71D(3)*"b"* as amended by 2013 Iowa Acts, House File 590, are applicable, reports of denial of critical care by failure to provide adequate clothing or failure to provide adequate supervision and physical abuse where abuse has been confirmed and determined to be minor, isolated, and unlikely to reoccur shall not be placed on the central abuse registry as a case of founded child abuse. The confirmed abuse shall be placed on the registry unless all three conditions are met.

175.39(1) *Confidentiality of founded child abuse report and data.* The confidentiality of report and disposition data pertaining to founded child abuse shall be maintained as provided in Iowa Code chapter 235A. Access to the report and disposition data on founded child abuse is authorized only as provided in Iowa Code section 235A.15.

175.39(2) *Sealing and expungement of founded child abuse report and data.* Report and disposition data pertaining to founded child abuse shall be sealed and expunged as provided in Iowa Code section 235A.18.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.40(235A) Retroactive reviews. Rescinded IAB 9/7/11, effective 8/15/11.

441—175.41(235A) Access to child abuse information. Requests for child abuse information shall include sufficient information to demonstrate that the requesting party has authorized access to the information.

175.41(1) *Written requests.* Requests for child abuse information shall be submitted on a Request for Child Abuse Information form to the county office of the department, except requests made for the purpose of determining employability of a person in a department-operated facility shall be submitted to the central abuse registry. Subjects of a report may submit a request for child abuse information to the county office of the department on a request for child abuse information form, a notice of child abuse assessment: founded form, a notice of child abuse assessment: confirmed not registered form, a notice of child abuse assessment: not confirmed form, or a family assessment report form. The county office is granted permission to release child abuse information to the subject of a report immediately upon verification of the identity and subject status.

175.41(2) *Oral requests.* Oral requests for child abuse information may be made when a person making the request believes that the information is needed immediately and if the person is authorized to access the information. When an oral request to obtain child abuse information is granted, the person approving the request shall document the approval to the central abuse registry through use of a request for child abuse information form or a notice of child abuse assessment: founded form.

Upon approval of any request for child abuse information authorized by this rule, the department shall withhold the name of the person who made the report of child abuse unless ordered by a juvenile court or district court after a finding that the person's name is needed to resolve an issue in any phase of a case involving child abuse. Written requests and oral requests do not apply to child abuse information that is disseminated to an employee of the department, to a juvenile court, or to the attorney representing the department as authorized by Iowa Code section 235A.15.

175.41(3) *Written authorizations.* Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on an Authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information. The department shall not provide requested information when the authorization form is incomplete. Incomplete authorization forms shall be returned to the requester.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.42(235A) Person conducting research. The supervisor of the central abuse registry shall be responsible for determining whether a person requesting child abuse information is conducting bona fide research, whether the research will further the official duties and functions of the central abuse registry, and whether identified information is essential to the research design. A bona fide research design is one which shows evidence of a good-faith, academically objective and sincere intent to add to the body of knowledge about child abuse. To make this determination, the central abuse registry shall require the person to submit credentials and the research design. Additional criteria for approval of a research project may include whether the research involves contact with subjects of child abuse information, and whether contact with department personnel is required to complete the research design. If it is determined that the research will involve use of identified information, the central abuse registry shall also determine under what circumstances and in what format the information is to be used and shall execute an agreement with the researcher which will enable the researcher to obtain access to identified information on subjects of child abuse investigations, as an agent of the central abuse registry. The department will require the researcher to assume costs incurred by the department in obtaining or providing information for research purposes. The department shall keep a public record of persons conducting this research.

175.42(1) *Child abuse factors.* For purposes of conducting research pursuant to Iowa Code sections 235A.15 and 235A.23, official duties and functions of the central abuse registry shall include analysis or identification of child abuse factors in at least one of the following areas:

a. Causes of abuse—victim, parent and perpetrator characteristics, types of abuse, and correlations to family and environmental factors.

b. Effects of abuse—immediate and long-term effects of abuse on the individual child victim, the child's family and the perpetrator, in areas such as family functioning, foster placement, emotional and medical problems, and criminal activity; and effects of abuse on the community and society in general.

c. Prevention of abuse—intervention, prevention and treatment strategies.

d. Treatment of abuse—impact of service delivery upon recidivism and maintenance of the family unit.

e. Reporting of abuse—mandatory and permissive reporter characteristics, training needs, and perception of the department's protective services to children and families.

f. Identification of strengths and weaknesses in statute, policy or practice concerning child abuse services.

175.42(2) *Guidelines.* To be accepted by the central abuse registry, a research proposal originating outside the department shall meet the following guidelines:

a. The proposal shall meet the criteria listed above as "official duties and functions" of the central abuse registry.

b. The research shall be conducted by a competent researcher, evidenced by affiliation with a recognized human services agency, government body, or academic, social work or medical facility. The researcher shall demonstrate an ability to conduct nonbiased research and present findings in a professional and responsible manner which will benefit the department in providing protective services to children and families.

c. The proposed research shall not unduly interfere with the ongoing duties and responsibilities of department staff.

d. When the proposed research includes contact with subjects of child abuse information, the research design shall reflect a plan for initial subject contact by the department, which includes the following:

(1) Subjects shall be informed in writing of their right to refuse to participate in the research.

(2) Subjects shall receive written assurance that their participation in the research will not affect eligibility for services.

(3) Department staff shall be advised of research goals and procedures prior to contact with subjects, in order to answer questions which may arise.

(4) Subjects shall receive written assurance that when identifying information is released by the central abuse registry to research staff, the information will remain confidential and that all child abuse information will be deidentified prior to publication of the research findings.

175.42(3) *Approval procedures.* Procedures for approval of a research proposal are conducted as follows:

a. The supervisor of the central abuse registry shall designate a person to be the single point of contact (SPOC) for all research proposals requesting child abuse information or involving department staff who provide child protective services. All proposals shall be routed to the SPOC at the Division of Adult, Children and Family Services, Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Having received a research proposal, the SPOC shall log the date the proposal was received and other identifying information about the researcher and the research design and shall convene a research advisory committee to review the proposal. This committee may consist of:

(1) The unit supervisor of the child and dependent adult abuse registry, when applicable.

(2) The unit managers for the programs addressed by the research proposal.

(3) The research specialist.

(4) Representatives from the field, including a service area manager or designee and one representative from a service area, appointed by the service area manager, if a specific service area is involved.

(5) A representative from the department's division of data management, when the proposal involves use of one of the department's computerized data systems.

(6) A representative of the attorney general's office, when the proposal involves legal questions or issues.

(7) Other persons whom the SPOC may designate to assist in the review.

c. The SPOC is responsible for ensuring that advisory committee members receive copies of the research proposal.

d. The advisory committee may meet in person or by teleconference.

e. The researcher may, at the discretion of the SPOC, be provided an opportunity to address the advisory committee concerning the research proposal and answer questions about the research design.

f. The committee shall determine the value of the proposed research and formulate recommendations for acceptance of the proposal (with conditions as necessary) or rejection of the proposal (with rationale for the rejection). These recommendations shall be submitted to the SPOC.

g. The SPOC shall transmit the committee's recommendations, with additional comments and recommendations, as needed, to the division administrators for the divisions involved.

h. The division administrators shall review committee recommendations and submit the research proposal to the director or designee for final approval.

i. After review by the director, the proposal shall be returned to the SPOC, who shall notify the researcher of the director's decision, which decision shall be final.

j. If the research proposal is approved, the SPOC shall prepare a written research agreement with the researcher which provides:

(1) The purpose of the research.

(2) The research design or methodology.

(3) The control of research findings and publication rights of all parties, including the deidentification of child abuse information prior to publication.

(4) The duties of all parties in conducting the research.

(5) The transfer of funds, if applicable.

k. The SPOC shall be responsible for securing written approval of the research agreement from the attorney general's office, applicable division administrators, and the researcher.

l. The SPOC shall be responsible for maintaining the research agreement throughout the research project and renewing or modifying the agreement when necessary.

441—175.43(235A) Child protection services citizen review panels. The purposes of the child protection services citizen review panels established in this rule are to comply with requirements set forth by the Child Abuse Prevention and Treatment Act and to take advantage of this process to identify strengths and weaknesses of the child protective service system as a whole, including community-based services and agencies. The specific objectives are to clarify expectations for child protective services with current policy; to review consistency of practice with current policy; to analyze trends and recommend policy to address them; and to provide feedback on what is or is not working, and why, and to suggest corrective action if needed.

175.43(1) *Establishment of panels.* The department shall establish at least three panels, with at least one panel each at the state level, multicounty level, and county level. The department may designate as panels one or more existing entities established under state or federal law, such as multidisciplinary teams, if the entities have the capacity to satisfy the requirements of the function of a citizen review panel set forth in the Child Abuse Prevention and Treatment Act and the department ensures that the entities will satisfy the requirements. The department shall establish procedures to be used for selecting the panels.

175.43(2) *Membership of panels.* Each panel established shall be composed of a multidisciplinary team of volunteer members who are broadly representative of the community in which the panel is established, including members who possess knowledge and skills related to the diagnosis, assessments, and disposition of child abuse cases, and who have expertise in the prevention and treatment of child abuse. The membership of each panel shall include professionals practicing in the disciplines of medicine, nursing, public health, substance abuse, domestic violence, mental health, social work, child development, education, law, juvenile probation, law enforcement; or representatives from organizations that advocate for the protection of children. The panel shall function under the leadership

of a chairperson and vice-chairperson who are elected annually by the membership. Members shall enter into a contract with the department.

175.43(3) *Meetings.* Each panel established pursuant to this rule shall meet not less than once every three months.

175.43(4) *Functions.* Each panel established pursuant to this rule shall:

a. Evaluate the extent to which the department effectively discharges the child protection responsibilities in accordance with: the state plan and the child protection standards under subsection (b) of the Child Abuse Prevention and Treatment Act of 1996; the child protection duties of the department set forth in Iowa Code chapters 232 and 235A; and any other criteria that the panel considers important to ensure the protection of children, including:

(1) A review of the extent to which the child protective services system is coordinated with the foster care and adoption programs established under Part E of Title IV of the Social Security Act (42 USCS 670 et seq.); and

(2) A review of child fatalities and near fatalities.

b. Provide for public outreach and comment in order to:

(1) Assess the impact of current procedures and practices upon children and families in the community; and

(2) Make recommendations to the state and the public on improving the child protective services system at the state and local levels.

175.43(5) *Redissemination.* No panel member shall redisseminate child abuse information obtained through the citizen review panel. This shall not preclude redissemination of information as authorized by Iowa Code section 235A.17 when an individual panel member has received information as a result of another authorized access provision of the Iowa Code.

175.43(6) *Department not bound.* The department shall consider the recommendations of the panel but shall not, in any way, be bound by the recommendations.

175.43(7) *Confidentiality.* Members and staff of a panel may not disclose child abuse information about any specific child abuse case to any person or government official and may not make public any information unless authorized by the Iowa Code to do so.

175.43(8) *Reports.* Each panel established under this rule shall prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the panel.

175.43(9) *Staff assistance.* The department shall provide staff assistance to citizen review panels for the performance of their duties, upon request of the panel.

175.43(10) *Access to child abuse information.* Citizen review panels shall be under contract to carry out official duties and functions of the department and have access to child abuse information according to Iowa Code section 235A.15 [2*"e"*(2)].

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

These rules are intended to implement Iowa Code sections 232.68, 232.71D, 232.67, 232.69, 232.70, 232.71B, 232.71C, and 232.72 to 232.77 and Iowa Code chapter 235A.

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[1] Effective date of amendments to subrule 175.8(4), paragraph *"a,"* subparagraphs (7), (9), and (10); subrule 175.8(5); rules 175.9 and 175.15 delayed 70 days by the Administrative Rules Review Committee.

[2] Effective date of 175.25(4)*"d"* delayed 70 days by the Administrative Rules Review Committee at its meeting held January 3, 1996; delay lifted by the Committee at its meeting held February 5, 1996, effective February 6, 1996.

[3] Effective date of amendments adopted in ARC 7975A delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

CHAPTER 176
DEPENDENT ADULT ABUSE

[Prior to 7/1/83, Social Services[770] Ch 156]
[Previously appeared as Ch 156—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—176.1(235B) Definitions.

"Adult abuse" means either:

1. Any of the following as a result of the willful or negligent acts or omissions of a caretaker:

- Physical injury to, or injury which is at variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.
- Exploitation of a dependent adult, which means the act or process of taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.
- The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health.
- Sexual exploitation of a dependent adult by a caretaker. "Sexual exploitation" means any consensual or nonconsensual sexual contact with a dependent adult which includes but is not limited to kissing; touching of the clothed or unclothed inner thigh, breast, groin, buttock, anus, pubes, or genitals; or a sex act, as defined in Iowa Code section 702.17. "Sexual exploitation" includes the transmission, display, taking of electronic images of the unclothed breast, groin, buttock, anus, pubes, or genitals of a dependent adult by a caretaker for a purpose not related to treatment or diagnosis or as part of an ongoing assessment, evaluation or investigation. "Sexual exploitation" does not include touching which is part of a necessary examination, treatment, or care by a caretaker acting within the scope of the practice or employment of the caretaker; the exchange of a brief touch between the dependent adult and a caretaker for the purpose of reassurance, comfort, or casual friendship; or touching between spouses.

2. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult.

"Appropriate evaluation or assessment" means that evaluation or assessment reasonably believed by the department to be warranted by the facts and circumstances of the case as reported.

"Assault" means "assault" as defined in Iowa Code section 708.1.

"At-risk adult" means an adult who, because of a significant impairment due to a physical or mental disability or both, is unable to meet essential daily needs without assistance and whose personal health or safety is at risk due to such impairments, the environment, substance abuse problems, a lack of services or social supports, a refusal to accept services, or other risk factors identified through an assessment.

"Caretaker" means a related or nonrelated person who has the responsibility for the protection, care, or custody of a dependent adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court.

"Collateral sources" means any person or agency who is presently providing, either in a professional or paraprofessional capacity, service to the dependent adult, including, but not limited to, doctors, counselors, and public health nurses.

"Confidentiality" means the withholding of information from any manner of communication, public or private.

"Denial of critical care" exists when the dependent adult's basic needs are denied or ignored to such an extent that there is immediate or potential danger of the dependent adult suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the dependent adult's serious social maladjustment, or is a gross failure of the caretaker to meet the emotional needs of the dependent adult necessary for normal functioning, or is a failure of the caretaker to provide for the proper supervision of the dependent adult.

"Department" means the department of human services and includes the county and central offices of the department, unless otherwise specified.

"Dependent adult" means a person 18 years of age or older who is unable to protect the person's own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another.

"Expungement" means the process of destroying dependent adult abuse information.

"Immediate danger to health or safety" means a situation in which death or severe bodily injury could reasonably be expected to occur without intervention.

"Immediately" means within 24 hours when referring to mandatory reporters reporting suspected abuse of a dependent adult.

"Individual employed as an outreach person" means a person who, in the course of employment, makes regular contacts with dependent adults regarding available community resources.

"Informed consent" (as used in Iowa Code paragraph 235B.2(5)*"c"*) means a dependent adult'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., knowledge of risks involved or alternatives.

"Minimum food, shelter, clothing, supervision, physical and mental health care, and other care" means that food, shelter, clothing, supervision, physical and mental health care, and other care which, if not provided, would constitute denial of critical care.

"Multidisciplinary team" shall mean a membership of individuals who possess knowledge and skills related to the diagnosis, assessment, and disposition of dependent adult abuse cases and who are professionals practicing in the disciplines of medicine, public health, social work, law, law enforcement and other disciplines relative to dependent adults. Members of the team shall include, but are not limited to, persons representing the area agencies on aging, county attorneys, health care providers, and others involved in advocating or providing services for dependent adults.

"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, or physical injury which is at variance with the history given of it.

"Preponderance of evidence" shall mean evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

"Proper supervision" means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall a person place a dependent adult in a situation that may endanger the dependent adult's life or health or cruelly punish or unreasonably confine the dependent adult.

"Registry" means the central registry for dependent adult abuse information established in Iowa Code Supplement section 235B.5.

"Report" means a verbal or written statement, made to the department, which alleges that dependent adult abuse has occurred.

[**ARC 8099B**, IAB 9/9/09, effective 8/13/09; **ARC 9258B**, IAB 12/1/10, effective 2/1/11]

441—176.2(235B) Denial of critical care. The failure on the part of the caretaker or dependent adult to provide for minimum food, shelter, clothing, supervision, physical or mental care, and other care necessary for the dependent adult's health and welfare when financially able to do so or when offered financial and other reasonable means to do so shall constitute denial of critical care to that dependent adult.

441—176.3(235B) Appropriate evaluation. Immediately upon receipt of a dependent adult abuse report the worker shall conduct an intake sufficient to determine whether the allegation constitutes a report of dependent adult abuse.

176.3(1) Dependent adult abuse reports shall be evaluated when all of the following criteria are alleged to be met:

a. The person is a dependent adult.

b. Dependent adult abuse exists as defined in Iowa Code section 235B.2.

c. A caretaker exists in reports of physical injury to or unreasonable confinement or cruel punishment of a dependent adult; commission of a sexual offense; exploitation; and deprivation by another person of food, shelter, clothing, supervision, physical and mental health care and other care necessary to maintain life or health.

176.3(2) Nondependent adult abuse situations. The following are not dependent adult abuse situations:

a. A report of domestic abuse under Iowa Code chapter 236, Domestic Abuse, does not in and of itself constitute a report of dependent adult abuse.

b. Circumstances in which the dependent adult declines medical treatment if the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.

c. Circumstances in which the dependent adult's caretaker, acting in accordance with the dependent adult's stated or implied consent, declines medical treatment if the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.

d. Withholding and withdrawing of health care from a dependent adult who is terminally ill in the opinion of a licensed physician when the withholding and withdrawing of health care is done at the request of the dependent adult or at the request of the dependent adult's next-of-kin or guardian pursuant to the applicable procedures under Iowa Code chapter 125, 144A, 222, 229, or 633.

e. All persons legally incarcerated in a penal setting, either in a local jail or confined to the custody of the director of the department of corrections.

176.3(3) Reports of dependent adult abuse which are the result of the acts or omissions of the dependent adult shall be collected and maintained in the files of the dependent adult as assessments only and shall not be included on the central registry. The central registry shall be notified as to the disposition of the assessment.

176.3(4) Confirmed, not registered. Reports of physical abuse or denial of critical care by a caretaker that would otherwise be founded reports shall be considered confirmed, not registered reports if the abuse is determined to be minor, isolated, and unlikely to reoccur. These reports shall be assessments and shall not be included on the central abuse registry. The assessment shall be maintained in the local office as directed in subrule 176.13(4).

441—176.4(235B) Reporters. The central registry and county office shall accept reports from mandatory reporters or any other person who believes dependent adult abuse has occurred.

176.4(1) Mandatory reporters shall:

a. Report suspected abuse of a dependent adult within 24 hours of becoming aware of an abusive incident.

b. Make a written report within 48 hours after an oral report.

176.4(2) The reporter may use the department's Form 470-2441, Suspected Dependent Adult Abuse Report, or may use a form developed by the reporter that meets the requirements of Iowa Code section 235B.3.

441—176.5(235B) Reporting procedure.

176.5(1) Each report made by someone other than a mandatory reporter may be oral or written.

176.5(2) The report shall be made by telephone or otherwise to the department of human services. When the person making the report has reason to believe that immediate protection for the dependent adult is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

176.5(3) The department of human services shall:

a. Immediately, upon receipt of a report, make an oral report to the registry;

b. Forward a copy of the report to the registry; and

c. Promptly notify the appropriate county attorney of the receipt of any report.

176.5(4) The report shall contain the following information, or as much thereof as the person making the report is able to furnish:

a. The names and home addresses of the dependent adult, appropriate relatives, caretakers, and other persons believed to be responsible for the care of the dependent adult.

b. The dependent adult's present whereabouts if not the same as the address given.

c. The reason the adult is believed to be dependent. Dependency is the first criterion to be considered before beginning an evaluation.

d. The dependent adult's age.

e. The nature and extent of the adult abuse, including evidence of previous adult abuse. The existence of alleged adult abuse is the second criterion to be considered before beginning an evaluation.

f. Information concerning the suspected adult abuse of other dependent adults in the same residence.

g. Other information which the person making the report believes might be helpful in establishing the cause of the abuse or the identity of the person or persons responsible for the abuse, or helpful in providing assistance to the dependent adult.

h. The name and address of the person making the report.

176.5(5) A report shall be accepted whether or not it contains all of the information requested in 176.5(4), and may be made to the department, county attorney, or law enforcement agency. When the report is made to any agency other than the department of human services, that agency shall promptly refer the report to the department.

441—176.6(235B) Duties of the department upon receipt of report.

176.6(1) When a report is received, the department shall promptly commence an appropriate evaluation or assessment, except that the department of inspections and appeals is responsible for the evaluation and disposition of a case of adult abuse in a health care facility, including hospitals as defined in Iowa Code section 135B.1 and facilities as defined in Iowa Code section 135C.1. The department shall forward all reports and other information concerning adult abuse in a health care facility to the department of inspections and appeals on the first working day following the submitting of the report. The department of inspections and appeals shall inform the registry of all actions taken or contemplated concerning the evaluation or disposition of a case of adult abuse in a health care facility. The primary purpose of the evaluation or assessment by the department shall be the protection of the dependent adult named in the report.

176.6(2) The evaluation or assessment shall include all of the following:

a. Identification of the nature, extent, and cause of the adult abuse, if any, to the dependent adult named in the report.

b. The identification of the person or persons responsible for the adult abuse.

c. A determination of whether other dependent adults in the same residence have been subjected to adult abuse.

d. A critical examination of the residential environment of the dependent adult named in the report, and the dependent adult's relationship with caretakers and other adults in the same residence.

e. A critical explanation of all other pertinent matters.

176.6(3) The evaluation or assessment, with the consent of the dependent adult or caretaker, when appropriate, may include a visit to the residence of the dependent adult named in the report and an examination of the dependent adult. If permission to enter the residence and to examine the dependent adult is refused, the district court, upon a showing of probable cause that a dependent adult has been abused, may authorize a person, authorized by the department, to make an evaluation or assessment, to enter the residence of, and to examine the dependent adult.

Upon a showing of probable cause that a dependent adult has been financially exploited, a court may authorize a person, also authorized by the department, to gain access to the financial records of the dependent adult.

176.6(4) County attorneys, law enforcement agencies, multidisciplinary teams as defined in Iowa Code section 235B.1, subsection 1, and social services agencies in the state shall cooperate and assist in

the evaluation or assessment upon the request of the department. County attorneys and appropriate law enforcement agencies shall also take any other lawful action necessary or advisable for the protection of the dependent adult.

176.6(5) Completion of evaluation or assessment report. Upon completion of its evaluation or assessment, the department shall complete a report that describes its findings and includes all actions taken or contemplated.

a. The department shall complete its report within 20 working days of the receipt of the abuse allegations, unless the worker's supervisor grants an extension of time for good cause shown. The worker's supervisor may grant an extension for a maximum of 30 working days. No more than three extensions shall be granted.

b. Upon completion of an evaluation, the department shall enter its report into the system on dependent adults (SODA).

c. Upon completion of an assessment when the alleged abuse is the result of the acts or omissions of the dependent adult, the department shall place the report in the case file of the dependent adult and on SODA.

176.6(6) Report to county attorney. The department shall transmit a copy of the report of its evaluation or assessment to the appropriate county attorney. The county attorney shall notify the local office of the department of any actions or contemplated actions with respect to a suspected case of adult abuse.

176.6(7) Based on the evaluation, the department shall complete an assessment of services needed by a dependent adult believed to be the victim of abuse, the dependent adult's family, or a caretaker. The department shall explain that the department does not have independent legal authority to compel the acceptance of protective services. Upon voluntary acceptance of the offer of services, the department shall make referrals or may provide necessary protective services to eligible dependent adults, their family members, and caretakers.

176.6(8) Court action. When, upon completion of the evaluation or assessment or upon referral from the state department of inspections and appeals, the department determines that the best interests of the dependent adult require court action, the department shall initiate action for the appointment of a guardian or conservator, or for admission or commitment to an appropriate institution or facility, pursuant to the applicable procedures under Iowa Code chapter 125, 222, 229, or 633. The department may pursue other remedies provided by law pursuant to the applicable procedures under Iowa Code sections 235B.17, 235B.18, 235B.19, and 235B.20 or any other legal remedy which provides protection to a dependent adult. The appropriate county attorney shall assist the department in the preparation of the necessary papers to initiate the action, and shall appear and represent the department at all district court proceedings.

176.6(9) The department shall assist the district court during all stages of court proceedings involving a suspected case of adult abuse.

176.6(10) In every case involving adult abuse which is substantiated by the department and which results in a judicial proceeding on behalf of the dependent adult, legal counsel shall be appointed by the court to represent the dependent adult in the proceedings. The court may also appoint a guardian ad litem to represent the dependent adult when necessary to protect the dependent adult's best interests. The same attorney may be appointed to serve both as legal counsel and as guardian ad litem. Before legal counsel or a guardian ad litem is appointed pursuant to Iowa Code section 235B.3, subsection 7, paragraph *"c,"* the court shall require the dependent adult and any person legally responsible for the support of the dependent adult to complete under oath a detailed financial statement. If, on the basis of that financial statement, the court deems that the dependent adult or the legally responsible person is able to bear all or a portion of the cost of the legal counsel or guardian ad litem, the court shall so order. In cases where the dependent adult or the legally responsible person is unable to bear the cost of the legal counsel or guardian ad litem, the expense shall be paid by the county.

176.6(11) Notification of licensing authority. Based on information discovered during an evaluation of dependent adult abuse in a program providing care to a dependent adult, the department shall notify

the licensing or accrediting authority for the program, the governing body of the program, and the administrator in charge of the program of any of the following:

a. A violation of program policy noted in the evaluation.

b. An instance in which program policy or lack of program policy may have contributed to the dependent adult abuse.

c. An instance in which general practice in the program appears to differ from the program's policy.

The licensing or accrediting authority, the governing body, and the administrator in charge of the program shall take any lawful action which may be necessary or advisable to protect dependent adults receiving care in the program.

176.6(12) Assessments by other agencies. The department may approve agencies considered capable and appropriate to complete assessments of dependent adults who are suspected of being abused.

a. The department may make a referral to an approved agency to complete an assessment of a dependent adult who is suspected of being abused, in conjunction with a department abuse evaluation or assessment on the dependent adult.

b. The department may use information obtained from the assessment completed by the approved agency in the abuse evaluation or assessment. The department has complete authority in determining the conclusions of the abuse evaluation or assessment.

176.6(13) Referrals to other agencies. During an assessment or evaluation of suspected abuse of a dependent adult, the department shall:

a. Make a referral to the division of labor services of the department of workforce development if an issue is discovered that concerns wages, workplace safety, or labor and employment matters under the jurisdiction of that agency.

b. Make a referral to the civil rights commission if an issue is discovered that involves discrimination under the jurisdiction of that agency.

176.6(14) Assessment of dependency and risk. After the first visit to a dependent adult who is alleged to be abused, the department shall complete an assessment of the adult using Form 470-3246, Dependent Adult Assessment Tool. The department shall assess:

a. The adult's dependency,

b. The risk to the adult's health or safety, and

c. The areas in which the adult is either dependent or independent.

176.6(15) Follow-up for at-risk adults. When it has not been possible or necessary to obtain a court order for services to an at-risk adult, the department shall attempt to persuade the at-risk adult to agree to accept services and to participate in preparing a safety plan. If the adult refuses to sign Form 470-4835, Safety Plan for At-Risk Adult, and to accept services, the department shall provide periodic visits.

a. *Purpose.* The purpose of the visits shall be to:

(1) Assess the adult for increased risk or impairment,

(2) Monitor the adult's situation to determine the feasibility of intervening with protective services, and

(3) Persuade the adult to accept services and to sign Form 470-4835, Safety Plan for At-Risk Adult.

b. *Exemption.* If it has been determined there is a physical threat to the safety of the department employee who is attempting to visit an at-risk adult, the department shall not attempt a periodic visit unless the physical threat to safety has been removed.

c. *Criteria to continue visits.* Periodic visits shall continue if:

(1) The adult's health or safety has deteriorated somewhat but not to the point that a court order is necessary; or

(2) The adult's health or safety has remained the same and there is a possibility the adult may in the future agree to services and to participating in preparing a safety plan.

d. *Criteria to end visits.* Periodic visits shall be terminated when:

(1) The adult agrees to services and services are arranged; or

(2) The adult's health or safety has deteriorated to the point that the department has requested court action pursuant to subrule 176.6(8); or

(3) The adult's health or safety has not changed six months after the initial report of alleged abuse; there appears no possibility the adult will ever agree to services; and the adult is competent to make decisions.

[**ARC 9258B**, IAB 12/1/10, effective 2/1/11]

441—176.7(235B) Appropriate evaluation or assessment.

176.7(1) After receipt of the report alleging dependent adult abuse, the field worker shall make an evaluation or assessment to determine whether the information as reported, other known information, and any information gathered as a result of the worker's contact with collateral sources would tend to corroborate the alleged abuse.

176.7(2) When the information gathered in the evaluation or assessment tends to corroborate, or the worker is uncertain as to whether it repudiates the allegations of the report, the worker shall immediately continue the evaluation or assessment by making a reasonable effort to ensure the safety of the adult. The worker and the worker's supervisor shall determine whether an immediate threat to the physical safety of the adult is believed to exist.

a. If an immediate threat to the physical safety of the adult is believed to exist, the field worker shall make every reasonable effort to examine the adult, as authorized by 176.6(3), within one hour after receipt of the report and shall take any lawful action necessary or advisable for the protection of the adult.

b. When physical safety of the adult is not endangered, the worker shall make every reasonable effort to examine the adult within 24 hours after receipt of the report.

176.7(3) In the event the information gathered in the evaluation or assessment fails to corroborate the allegation of adult abuse, the worker, with approval of the supervisor, may terminate the evaluation or assessment and submit the report required by subrule 176.6(5).

441—176.8(235B) Immunity from liability for reporters. A person participating in good faith in making a report or cooperating or assisting the department in evaluating or assessing a case of dependent adult abuse has immunity from liability, civil or criminal, which might otherwise be incurred or imposed based upon the act of making the report or giving the assistance. The person has the same immunity with respect to participation in good faith in a judicial proceeding resulting from the report or assistance or relating to the subject matter of the report or assistance.

441—176.9(235B) Registry records. Central registry records shall be kept in the name of the dependent adult and cross-referenced in the name of the caretaker.

441—176.10(235B) Adult abuse information disseminated.

176.10(1) *Requests for information.* Written requests for adult abuse information by the subject of a report as defined in subrule 176.10(3), paragraph *"a,"* may be submitted to the county office of the department on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

Oral requests for dependent adult abuse information may be made to the county office or the central registry when the person making the request believes that the information is needed immediately and the person is authorized to access the information, pursuant to the requirements of Iowa Code section 235B.7, subsection 2. If a request is made orally by telephone, a written request shall be filed within 72 hours of the oral request using Form 470-0612, Request for Dependent Adult Abuse Registry Information. When an oral request to the county office to obtain dependent adult abuse information is granted by the central registry, the county shall document the approval to the central registry through use of Form 470-0612.

All other requests for information shall be made to the central registry by mail or fax pursuant to the requirements of Iowa Code section 235B.7.

176.10(2) *Verification of identity.* The county office shall verify the identity of the person making the request on Form 470-0612, Request for Dependent Adult Abuse Registry Information. Upon verification of the identity of the person making the request, the county office shall transmit the request to the central registry. The central registry shall verify the identity of persons making requests for information directly

to the central registry by telephone, mail, fax, or in person, on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

176.10(3) *Approval of requests.* The department shall grant access to dependent adult abuse information as authorized by Iowa Code section 235B.6. Upon approval of any request for dependent adult abuse information authorized by this rule, the department may withhold the name of the person who made the report of dependent adult abuse when the department finds that the disclosure of the person's identity would be detrimental to the person's interest.

176.10(4) *Requests concerning applicants for employment and employees of health care programs.* A health care program making a request for dependent adult abuse information for the purpose of determining employability, as authorized by Iowa Code section 235B.6, subsection 2, paragraph *"e,"* subparagraphs (6) and (7), and section 135C.33, subsection 6, shall request the information directly from the central registry or obtain the information from the Internet electronic information system maintained by the health facilities division of the department of inspections and appeals.

Requests made directly to the central registry shall be made on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

Health care programs requesting dependent adult abuse background checks on employee applicants and employees by use of the Internet electronic information system shall complete Form 470-3767, Non-Redissemination Agreement. The form shall be signed by the administrator of the health care program and be sent to the central registry before receipt of the information from the department. The administrator shall agree not to redisseminate dependent adult abuse information obtained through the Internet electronic information system, except as authorized in Iowa Code sections 235B.6 and 235B.8.

176.10(5) *Dissemination of undetermined reports.* Rescinded IAB 8/6/03, effective 7/10/03.

176.10(6) *Access to unfounded dependent adult abuse information.* Access to unfounded dependent adult abuse information is authorized only to:

a. Persons identified as subjects of a report, including the dependent adult named in a report as a victim, a guardian of a dependent adult named in a report as a victim, a person named in a report as having abused a dependent adult, or an attorney representing any of the above;

b. An employee or agency of the department of human services responsible for the evaluation or assessment of a dependent adult abuse report;

c. Registry or department personnel, when necessary to the performance of their official duties, or a person or agency under contract with the department to carry out official duties and functions of the registry;

d. The mandatory reporter who reported dependent adult abuse in an individual case;

e. The long-term care resident advocate, if the victim resides in a long-term care facility or the alleged perpetrator is an employee of a long-term care facility; and

f. A multidisciplinary team, if the department approves the composition of the team and determines that access to the team is necessary to assist in the evaluation, diagnosis, assessment, and disposition of a dependent adult abuse case.

176.10(7) *Requests concerning employees of department facilities.* When a request is made by the hiring authority of a department operated facility which provides direct client care and the request is made for the purpose of determining continued employability of a person employed, with or without compensation, by the facility, the information shall be requested directly from the central registry. The information requested shall be disseminated to the personnel office of the department. The personnel office shall redisseminate the information to the hiring authority for the person involved only upon a finding that the information has a direct bearing on employability of the person involved.

When the personnel office determines that the information has no direct bearing on employability, the hiring authority shall be notified that no job-related dependent adult abuse information is available. If the central registry and local office files contain no information, the hiring authority shall be so informed.

176.10(8) *Dependent adult abuse information disseminated and redisseminated.* Notwithstanding subrule 176.10(1), written requests and oral requests are not required for dependent adult abuse

information that is disseminated to an employee of the department of human services, a district court, or the attorney representing the department as authorized by Iowa Code section 235B.6.

176.10(9) *Required notification.* The department shall notify orally the subject of a report of the results of the evaluation or assessment. The department shall subsequently transmit a written notice to the subject which will include information regarding the results, the confidentiality provisions of Iowa Code sections 235B.6 and 235B.12, and the procedures for correction or expungement and appeal of dependent adult abuse information as provided in Iowa Code section 235B.10.

176.10(10) *Mandatory reporter notification.* The department shall attempt to notify orally the mandatory reporter who made the report in a dependent adult abuse case of the results of the evaluation or assessment and of the confidentiality provisions of Iowa Code sections 235B.6 and 235B.12. The department shall subsequently transmit a written notice on Form 470-2444, Adult Protective Notification, to the mandatory reporter who made the report. The form shall include information regarding the results of the evaluation or assessment and confidentiality provisions. A copy of the written notice shall be transmitted to the registry and shall be maintained by the registry as provided in Iowa Code section 235B.8.

176.10(11) *Subjects informed of abuse history.* The department may inform a subject of a dependent adult abuse report of a person's abuse history if the department determines at any time that disclosure is necessary for the protection of the dependent adult. A subject may be informed that a person is listed on the child or dependent adult abuse registry as having a founded abuse report or is listed on the sex offender registry.

441—176.11(235B) Person conducting research. The person in charge of the central registry shall be responsible for determining whether a person requesting dependent adult abuse information is conducting bona fide research. To make this determination, the central registry may require these persons to submit credentials and the research design. If the registry determines that identified information is essential to the research design, the registry shall also determine the method by which written permission is to be secured from the dependent adult or guardians of the dependent adult who could be identified by the information to be researched. Any costs incurred in the dissemination of the information shall be assumed by the researcher. The department will keep a public record of persons conducting research.

441—176.12(235B) Examination of information. Examination of information contained in the central registry can be made at the site of the central registry between the hours of 8 a.m. and 12 p.m. or 1 p.m. and 4 p.m., Monday through Friday, except state authorized holidays.

The person, or that person's attorney, requesting to examine the information in the registry which refers to that person, shall be allowed to inspect the information after providing appropriate identification.

441—176.13(235B) Dependent adult abuse information registry. The department shall create a central abuse registry for dependent adult abuse information. The registry shall collect, maintain, and disseminate dependent adult abuse information as follows:

176.13(1) *Founded reports.* A report of dependent adult abuse determined to be founded shall be retained and sealed by the registry in accordance with Iowa Code section 235B.9.

176.13(2) *Unfounded reports.* A report of dependent adult abuse determined to be unfounded shall be expunged five years from the date it is determined to be unfounded, in accordance with Iowa Code section 235B.9, subsection 2, as amended by 2009 Iowa Acts, Senate File 484.

176.13(3) *Rejected intakes.* Reports that are found not to meet the criteria to be accepted for evaluation or assessment of abuse shall be kept in the local office for three years from the date the report of abuse was determined to be rejected.

176.13(4) *Assessments.* Reports classified as assessments shall not be included in the central registry but shall be maintained in the local office. The central registry shall be notified of the disposition of the assessment report.

a. *Self-denial of critical care.* Reports involving abuse as a result of the acts or omissions of the dependent adult will be assessments. These reports shall be retained in the dependent adult's case file in the local office for five years and then destroyed.

b. *Confirmed, not registered.* Reports of dependent adult abuse where physical abuse or denial of critical care committed by a caretaker is confirmed but is determined to be minor, isolated, and unlikely to reoccur shall be assessments. These reports shall be maintained in the local office for five years and then destroyed unless a subsequent report of dependent adult abuse on the same caretaker is founded. If a subsequent report on the same caretaker is founded within the five-year period, the confirmed, not registered report shall be maintained in the local office for ten years from the date of the subsequent report and then sealed.

[**ARC 8099B**, IAB 9/9/09, effective 8/13/09]

441—176.14(235B) Central registry. Rescinded IAB 10/30/91, effective 1/1/92.

441—176.15(235B) Multidisciplinary teams.

176.15(1) *Purpose of multidisciplinary teams.* The service area shall establish multidisciplinary teams for the purpose of assisting the department in assessment, diagnosis, and disposition of reported dependent adult abuse cases. The disposition of a case may include the provision for treatment recommendations and services.

176.15(2) *Execution of team agreement.* When the team is established, the service area manager or designee and all team members shall execute an agreement on Form 470-2328, Dependent Adult Abuse Multidisciplinary Team Agreement. This agreement specifies:

a. That the team shall be consulted solely for the purpose of assisting the department in the assessment, diagnosis and treatment of dependent adult abuse cases.

b. That any team member may cause a dependent adult abuse case to be reviewed if approved by the department through use of the process of requesting adult abuse information specified in rule 176.10(235B).

c. That no team members shall redisseminate adult abuse information obtained solely through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code section 235B.6 when an individual team member has received information as a result of another authorized access provision of the Code.

d. That the department may consider the recommendation of the team in a specific dependent adult abuse case but shall not, in any way, be bound by the recommendations.

e. That any written report or document produced by the team pertaining to an individual case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of Iowa Code sections 235B.6 and 235B.8 and of 441—Chapter 176.

f. That any written records maintained by the team which identify an individual dependent adult abuse case shall be destroyed when the agreement lapses.

g. That consultation team members shall serve without compensation.

h. That any party to the contract may withdraw with or without cause upon the giving of 30 days' notice.

i. The date on which the agreement will expire.

176.15(3) *Filing of agreement.* Whenever a team is created, a copy of the executed contract shall be filed with the central registry in addition to any other requirement placed upon execution of agreements by the department.

441—176.16(235B) Medical and mental health examinations. In any year in which the legislature appropriates funds, the department shall administer a payment program for mental health or medical health examinations for subjects of dependent adult abuse reports.

176.16(1) *Conditions for payment.* The following conditions must be met before payment can be made:

a. Local resources to pay these costs must be exhausted.

b. The examination must be scheduled during the evaluation or assessment process.

c. Department staff must be involved in the decision to request the examination.

176.16(2) *Payment limits.* Payment for mental health examinations shall not exceed $250. Payment for a complete medical examination shall not exceed $160.

176.16(3) *Billing procedures.* Claims for payment shall be submitted to the division of behavioral, developmental, and protective services on Form GAX, General Accounting Expenditure, accompanied by a letter from department staff certifying that the necessary conditions for payment have been met.

441—176.17(235B) Request for correction or expungement. The department of human services is responsible for correction or expungement of reports prepared by department staff. The department of inspections and appeals is responsible for correction or expungement of reports prepared by that department's staff and that determination shall be binding on the registry.

176.17(1) Within six months of the date of the notice of evaluation results, a person may file with the registry a written statement to the effect that the dependent adult abuse information referring to the person is partially or entirely erroneous. The person may also request a correction of that information or of the findings of the report. The registry will record all requests and immediately forward the requests to the division of health facilities, department of inspections and appeals, when the reports were prepared by the department of inspections and appeals. The registry will notify the person requesting a correction that the report has been sent to the department of inspections and appeals.

176.17(2) Unless the designated department corrects the information or findings as requested, the designated department shall provide the person with an opportunity for a hearing as provided by 441—Chapter 7 to correct the information or the findings. The department may defer the hearing until the conclusion of a pending district court case relating to the information or findings.

These rules are intended to implement Iowa Code chapter 235B.

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CHAPTER 177
IN-HOME HEALTH RELATED CARE

[Prior to 7/1/83, Social Services[770] Ch 148]
[Previously appeared as Ch 148—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services [498]]

441—177.1(249) In-home health related care. In-home health related care is a program of nursing care in an individual's own home to provide personal services to an individual because such individual's state of physical or mental health prevents independent self-care.

441—177.2(249) Own home. Own home means an individual's house, apartment, or other living arrangement intended for single or family residential use.

441—177.3(249) Service criteria. The client shall require health care services that would require the supervision of a professional registered nurse working under the certification of a physician.

177.3(1) Skilled services may include but not be limited to:

a. Gavage feedings of individuals unable to eat solid foods.

b. Intravenous therapy administered only by a registered nurse.

c. Intramuscular injections required more than once or twice a week, excluding diabetes.

d. Catheterizations, continuing care of indwelling catheters with supervision of irrigations and changing of Foley catheter when required.

e. Inhalation therapy.

f. Care of decubiti and other ulcerated areas, noting and reporting to physician.

g. Rehabilitation services including, but not limited to: bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation and behavior modification.

h. Tracheotomy care.

i. Colostomy care until the individual is capable of maintaining the colostomy personally.

j. Care of medical conditions out of control which includes brittle diabetes and terminal conditions.

k. Postsurgical nursing care, but only for short time periods, and primarily for individuals with complications following surgery, or with the need for frequent dressing changes.

l. Monitoring medications needed for close supervision of medications because of fluctuating physical or psychological conditions, i.e., hypertensives, digitalis preparations, narcotics.

m. Diets which are therapeutic and require evaluation at frequent intervals.

n. Vital signs which is the recording and reporting of change in vital signs to the attending physician.

177.3(2) Personal care services may include but not be limited to:

a. Supervision on a 24-hour basis for physical or emotional needs.

b. Helping client with bath, shampoo, oral hygiene.

c. Helping client with toileting.

d. Helping client in and out of bed and with ambulation.

e. Helping client to reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by the 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.

441—177.4(249) Eligibility.

177.4(1) *Eligible individual.*

a. The individual shall be eligible for supplemental security income in every respect except for income.

b. The physician's certification shall include a statement of the specific health care services and that the services can be provided in the individual's own home. The certification shall be given on Form 470-0673, Physician's Report, or on a similar plan of care form presently used by public health agencies.

c. The individual shall live in the individual's own home.

d. The client shall require and be receiving qualified health care services. Qualified health care services are health care services supervised by a registered nurse and approved by a physician.

177.4(2) *Relationship to other programs.* In-home health related care shall be provided only when other existing programs cannot meet the client's need.

177.4(3) *Maximum costs.* The maximum cost of service shall be $480.55. The provider shall accept the payment made and shall make no additional charges to the recipient or others.

177.4(4) *Service plan.* A complete service plan shall be prepared which includes the services needed, the plan for providing these services, and the health care plan defined in rule 177.6(249).

177.4(5) *Certification procedure.* The approval of the case plan by the service area manager or designee shall constitute certification and approval for payment.

177.4(6) *Temporary absence from home.* The client will remain eligible and payment will be made for services for a period not to exceed 15 days in any calendar month when the client is absent from the home for a temporary period. Payment will not be authorized for over 15 days for any continuous absence whether or not the absence extends into a succeeding month or months.

177.4(7) *Income for adults.* The countable income of the individual and spouse living in the home shall be limited to $480.55 per month if one needs care or $961.10 if both need care, after the following disregards from gross income:

a. The amount of the basic supplemental security income standard for an individual or a couple, as applicable.

b. When income is earned, $65.00 plus one-half of any remaining income.

c. The amount of the supplemental security income standard for a dependent plus any established unmet medical needs, for each dependent living in the home. Any income of the dependent shall be applied to the dependent's needs before making this disregard.

d. The amount of the established medical needs of the ineligible spouse which are not otherwise met.

e. The amount of the established medical needs of the applicant or recipient which are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

f. Rescinded, effective 7/1/84.

177.4(8) *Income for children.*

a. All income received by the parents in the home shall be deemed to the child with the following disregards:

(1) The amount of the basic supplemental security income standard for an individual when there is one parent in the home or for a couple when there are two parents in the home.

(2) The amount of the basic supplemental security income standard for a dependent for each ineligible child in the home.

(3) The amount of the unmet medical needs of the parents and ineligible dependents.

(4) When all income is earned, an additional basic supplemental security income standard for an individual in a one-parent home or for a couple in a two-parent home.

(5) When the income is both earned and unearned, $65.00 plus one-half of the remainder of the earned income.

b. The countable income of the child shall be limited to $480.55 per month after the following disregards from gross income:

(1) The amount of the basic supplemental security income standard for an individual.

(2) The amount of the established medical needs of the child which are not otherwise met and would not be met if the child were eligible for the medical assistance program.

(3) One-third of the child support payments received from an absent parent.

c. Rescinded, effective 7/1/84.

177.4(9) *Payment.* The client or the person legally designated to handle the client's finances shall be the sole payee for payments made under the program and shall be responsible for making payment to the provider except when the client payee becomes incapacitated or dies while receiving service.

a. The department shall have the authority to issue one payment to a provider on behalf of a client payee who becomes incapacitated or dies while receiving service.

b. When continuation of an incapacitated client payee in the program is appropriate, the department shall assist the client and the client's family to legally designate a person to handle the client's finances. Guardians, conservators, protective or representative payees, or persons holding power of attorney are considered to be legally designated.

c. Payment for the program shall be approved effective as of the date of application or the date all eligibility requirements are met and qualified health care services are provided, whichever is later, notwithstanding 42 U.S.C. 1382(c)(7).

177.4(10) *Application.* Application for in-home health-related care shall be made on Form 470-2927 or 470-2927(S), Health Services Application. An eligibility determination shall be completed within 30 days from the date of the application, unless one or more of the following conditions exist:

a. An application has been filed and is pending for federal supplemental security income benefits.

b. The application is pending because the department has not received information, which is beyond the control of the client or the department.

c. The application is pending due to the disability determination process performed through the department.

d. The application is pending because Form 470-0636, Provider Agreement, has not been completed and completion is beyond control of the client. When Form 470-0636 cannot be completed due to the client's failure to locate a provider, applications shall not be held pending beyond 60 days from the date of application.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09]

441—177.5(249) Providers of health care services.

177.5(1) *Age.* The provider shall be at least 18 years of age.

177.5(2) *Health assessment.* The provider shall obtain certification that the provider is physically and emotionally capable of providing assistance to another person who may have physical and emotional limitations.

a. The certification shall be based on an examination performed by a physician or advanced registered nurse practitioner or by a physician assistant who is working under the direction of a physician. If the provider works for an agency, the practitioner performing the examination may not be employed by the same agency.

b. The practitioner conducting the examination shall indicate the certification by signing Form 470-0672, Provider Health Assessment.

c. The certification shall be submitted to the department service worker:

(1) Before the provider agreement is signed, and

(2) Annually thereafter.

177.5(3) *Qualifications.* The provider shall be qualified by training and experience to carry out the health care plan as specified in rule 177.4(4).

177.5(4) *Relative.* The provider may be related to the client, so long as the provider is not a member of the family as defined in rule 441—130.1(234).

[**ARC 8912B**, IAB 6/30/10, effective 9/1/10]

441—177.6(249) Health care plan. The nurse shall complete the health care plan with the physician's approval. The health care plan shall include the specific types of services required, the method of providing those services, and the expected duration of services.

177.6(1) *Transfer from medical facility.* When the client is being transferred from a medical hospital or long-term care facility, the service worker shall obtain a transfer document describing the client's current care plan, to be provided to the nurse supervising the in-home care plan.

177.6(2) *Medical records.*

a. Medical records shall include, whenever appropriate, transfer forms, physician's certification and orders, interdisciplinary case plan, interdisciplinary progress notes, drug administration records, treatment records, and incident reports. The nurse shall be responsible for ensuring that record requirements are met.

b. Medical records shall be located in the nurse's case file, with a copy of the interdisciplinary plan of care and physician's plan of service in the service worker's file, and all other records available to the service worker. Upon termination of the in-home care plan, the records shall be maintained in the county office of the department of human services, or in the office of the public health nurse and available to the service worker, for five years or until completion of an audit.

c. The client or legal representative shall have the right to view the client's medical records.

177.6(3) *Review.* The continuing need for in-home health care services shall be reviewed:

a. At a minimum of every 60 days by the physician, including a written recertification of continuing appropriateness of the plan;

b. At a minimum of every six months by the service worker, including a review of the total care plan;

c. At a minimum of every 60 days by the nurse who shall review the nursing plan; or

d. More frequently if required by the physician, the service worker, or the nurse.

177.6(4) *Annual physical.* The client shall obtain a physical examination report annually and shall be under the regular supervision of a physician.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09]

441—177.7(249) Client participation.

177.7(1) All income remaining after the disregards in 177.4(7) and 177.4(8) shall be considered income available for services and shall be used for service costs before payment for in-home health care begins.

177.7(2) First month. When the first month of service is less than a full month, there is no client participation for that month. Payment will be made for the actual days of service provided according to the agreed-upon rate.

441—177.8(249) Determination of reasonable charges. Payment will be made only for reasonable charges for in-home health care services as determined by the service worker. Reasonableness shall be determined by:

177.8(1) *Community standards.* The prevailing community standards for cost of care for similar services.

177.8(2) *Services at no charge.* The availability of service providers at no cost to the department.

441—177.9(249) Written agreements.

177.9(1) *Independent contractor.* The provider shall be an independent contractor and shall in no sense be an agent, employee or servant of the state of Iowa, the Iowa department of human services, any of its employees, or of its clients.

177.9(2) *Liability coverage.* All professional health care providers shall have adequate liability coverage consistent with their responsibilities, as the department of human services assumes no responsibility for, or liability for, individuals providing care.

177.9(3) *Provider agreement.* The client and the provider shall enter into an agreement, using Form 470-0636, Provider Agreement, prior to the provision of service. Any reduction to the state supplemental assistance program shall be applied to the maximum amount paid by the department of human services as stated in the Provider Agreement by using Form 470-1999, Amendment to Provider Agreement.

441—177.10(249) Emergency services. Written instructions for dealing with emergency situations shall be completed by the nurse and maintained in the client's home and in the county department of human services office. The instructions shall include:

177.10(1) *Persons to notify.* The name and telephone number of the client's physician, the nurse, responsible family members or other significant persons, and the service worker.

177.10(2) *Hospital.* Information as to which hospital to utilize.

177.10(3) *Ambulance.* Information as to which ambulance service or other emergency transportation to utilize.

441—177.11(249) Termination. Termination of in-home health related care shall occur under the following conditions.

177.11(1) *Request.* Upon the request of the client or legal representative.

177.11(2) *Care unnecessary.* When the client becomes sufficiently self-sustaining to remain in the client's own home with services that can be provided by existing community agencies as determined by the service worker.

177.11(3) *Additional care necessary.* When the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

177.11(4) *Excessive costs.* When the cost of care exceeds the maximum established in 177.4(3).

177.11(5) *Other services utilized.* When the service worker determines that other services can be utilized to better meet the client's needs.

177.11(6) *Terms of provider agreement not met.* When it has been determined by the service worker that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

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These rules are intended to implement Iowa Code section 249.3(2)*"a"*(2).

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CHAPTER 178
Reserved

CHAPTER 179
WRAP-AROUND FUNDING PROGRAM
Rescinded IAB 7/11/01, effective 7/1/01

CHAPTER 180
RESPITE CARE SERVICES
Rescinded IAB 6/8/05, effective 7/1/05

CHAPTER 181
FAMILY PRESERVATION SUPPORTIVE AND NONREHABILITATIVE TREATMENT SERVICES
Rescinded IAB 4/11/07, effective 7/1/07

CHAPTER 182
FAMILY-CENTERED SERVICES
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 183
ADULT SUPPORT PROGRAM
[Prior to 9/23/87, see Human Services Department[441] Chs 178 and 179]
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT

DIVISION I
FAMILY SUPPORT SUBSIDY PROGRAM

PREAMBLE

The purpose of this division is to define and structure the family support subsidy program. This program is designed to assist families in staying together by defraying some of the costs of caring for a child with special needs living at home.

441—184.1(225C) Definitions.

"Department" means the department of human services.

"Family" means a family member and the parent or legal guardian of the family member.

"Family member" means a person less than 18 years of age who by educational determination has a moderate, severe, or profound educational handicap or special health care needs or who otherwise meets the definition of developmental disability in the federal Developmental Disabilities Act, Section 102(5), as codified in 42 U.S.C. 6001(5).

"Home" means the home of the parent or legal guardian of the family member.

"Legal guardian" means a person appointed by a court to exercise powers over a family member.

"Parent" means a biological or adoptive parent.

"Supplemental Security Income (SSI)" means financial assistance provided to individuals pursuant to Title XVI of the federal Social Security Act, 42 U.S.C. Sections 1381 to 1383c.

441—184.2(225C) Eligibility requirements. A child shall be eligible for the family support subsidy program if funds are available and all of the following requirements are met:

184.2(1) The child meets the definition of family member.

184.2(2) Rescinded IAB 6/27/90, effective 7/1/90.

184.2(3) The child is currently residing in the applicant's home, or there is a discharge plan for the child to return home in the next 60 calendar days.

184.2(4) The family resides in the state of Iowa.

184.2(5) The family's net taxable income for the calendar year immediately preceding the date of application did not exceed $40,000 unless it can be verified that their estimated taxable income for the year in which the application is made will be less than $40,000.

184.2(6) The applicant agrees that, if the child receives Medicaid, the subsidy shall only be used for the cost of services that are not covered by Medicaid. This subsidy is intended to complement but not supplant public assistance or social service benefits that are based on economic need and are available to the family through governmental programs or other means.

184.2(7) Exclusions. Unless a family requests and receives approval from the department for an exception to policy according to rule 441—1.8(17A,217), a family is not eligible to receive the family support subsidy if any of the following are applicable to the family or the family member for whom the application is submitted:

a. The family member is a special needs child who was adopted by the family, and the family is receiving financial assistance under Iowa Code section 600.17.

b. Medicaid home- and community-based waiver services are provided for the family member, and the family lives in a county in which comprehensive family support program services are available.

c. Medicaid home- and community-based waiver services are available to the family member under a consumer choices option.

441—184.3(225C) Application process. Applications for the family support subsidy program may be obtained at the local office of the department in the county in which the family resides. Arrangements shall be made through the local office for the parent or legal guardian to meet with a trained volunteer or staff person to respond to questions.

184.3(1) A parent or legal guardian who wishes to apply shall complete Form 470-2526, Application for Family Support Subsidy, and provide the following verification for each family member for whom application is being made:

a. Verification of the family's net taxable income for the previous calendar year, or estimated income for the current year.

b. Verification of educational or health care needs.

(1) If the child has undergone an educational evaluation and by educational determination has a moderate, severe, or profound educational handicap or special health care needs, either the child's school principal, local superintendent of schools or the director of special education for the area education association, or any person so designated by the above individuals, shall complete the educational sign-off portion of Form 470-2526, Application for Family Support Subsidy.

(2) If the child has not undergone an educational evaluation and, therefore, the parents or guardians are unable to obtain signatures on the educational sign-off portion of Form 470-2526, then the medical sign-off portion of Form 470-2526 shall be utilized. When using the medical sign-off portion of Form 470-2526, the doctor completing the form shall be familiar with the child and the definition of developmental disability as defined in the federal Developmental Disabilities Act, Section 102(5), as codified in 42 U.S.C. 6001(5), which is contained on the form itself. In addition, the doctor shall be a doctor of medicine (M.D.) or a doctor of osteopathic medicine and surgery (D.O.) and licensed to practice in the doctor's state of residence.

(3) The application shall identify the age at which the family member's eligibility shall end. The age identified is subject to approval by the department.

184.3(2) The date of application is the date that Form 470-2526 and all verifications specified in subrule 184.3(1) are received in the local office of the department. Application materials shall be processed in the office within two working days of receipt. Obtaining verifications is the responsibility of the applicant.

184.3(3) A determination of eligibility shall be made within 15 working days after the completed application and required verification are received by the department.

184.3(4) After funds appropriated for this purpose are obligated, pending applications will be denied.

a. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements.

b. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications and verification were received by the local office. In the event that more than one application is received at one time, families shall be entered on the waiting list on the basis of the day of the month of the child's birthday, the lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

441—184.4(225C) Family support services plan.

184.4(1) The special needs of the child and the family for the subsidy, and the resources available to meet those needs shall be identified on the application form.

184.4(2) The applicant shall agree that the subsidy will be used to meet the special needs identified in the plan or other special needs of the child and family.

184.4(3) Families shall retain the greatest possible flexibility in determining use of the subsidy, except a parent or legal guardian who receives family investment program benefits shall not use the subsidy to meet the basic needs of the family as defined in 441—subrule 41.28(2) or the special needs

as defined in 441—subrule 41.28(3). In addition, if the child receives Medicaid, the subsidy shall only be used for the cost of services which are not covered by Medicaid.

441—184.5(225C) Approval. Rescinded IAB 6/27/90, effective 7/1/90. Subrule 184.5(3) transferred to 184.3(4).

441—184.6(225C) Amount of subsidy payment.

184.6(1) *Monthly payment.* Families approved for payment shall receive an ongoing monthly payment that is determined by dividing the amount appropriated by the legislature by the number of available subsidy slots designated by the legislature for each state fiscal year. The number of slots and amount requested by the department shall be determined after consultation with the comprehensive family support council.

184.6(2) *Advance payment.* In addition, a one-time lump-sum advance payment of twice the monthly amount may be paid to the parent or legal guardian whose family member will be returning home for the purpose of preparing for in-home care.

184.6(3) *Effective date.* An approved subsidy shall be payable as of the first of the month following approval. A notice of decision stating that the application is approved shall be sent within two working days of the approval. The notice shall state the date payments will begin, the amount of monthly payments, and, if different, the amount of the first payment.

441—184.7(225C) Redetermination of eligibility.

184.7(1) The department shall send an application packet, which shall include instructions and necessary forms for verification of continuing eligibility, to all recipients of subsidy payments at least 30 calendar days prior to the deadline date for annual redetermination of eligibility. The completed Form 470-2526, Application for Family Support Subsidy, and required verification materials shall be submitted annually to the Department of Human Services, Division of MH/MR/DD, Hoover State Office Building, Des Moines, Iowa 50319-0114. If the signed application and verification of continuing eligibility are not received by the division by the last working day of the renewal month, the family's subsidy shall be terminated.

184.7(2) When funding allows additional individuals to be added to the subsidy program, they shall be taken from the statewide waiting list, and their eligibility shall be redetermined at that time. An application packet, which includes instructions and necessary forms for verification of continuing eligibility, shall be sent to these families for completion and returned to the Department of Human Services, Division of MH/MR/DD, Hoover State Office Building, Des Moines, Iowa 50319-0114, within timelines specified by the department. If the signed application and verification of continuing eligibility are not received by the timeline specified by the department, the family's name shall be dropped from consideration for receipt of the subsidy payments.

441—184.8(225C) Termination of subsidy payments.

184.8(1) The family support subsidy shall terminate at the end of the month in which any of the following occur and a notice shall be sent which states the reason for the termination:

a. The family member dies.

b. The family no longer meets one or more of the eligibility criteria outlined in rule 441—184.2(225C).

c. The parent or legal guardian has failed to provide information required for redetermination of eligibility as outlined in rule 441—184.7(225C).

d. No funds appropriated for this purpose are available.

184.8(2) The parent or legal guardian is required to report to the local office within ten working days any changes which may affect eligibility. Failure to do so may result in responsibility for repayment of funds and termination of the subsidy.

184.8(3) If funds are not sufficient to cover payments for all persons on the subsidy, persons will be terminated from the subsidy in inverse order to the dates they began receiving payments, i.e., the last

person to be added on to the subsidy being the first person to be removed. The person terminated will move back to the waiting list with the person's original application date dictating the person's position as stated in subrule 184.3(4). The division of MH/MR/DD is responsible for notifying the persons who will be removed from the subsidy for this reason.

441—184.9(225C) Appeals. The parent or legal guardian of the child may appeal a denial of an application or termination of the subsidy payment pursuant to 441—Chapter 7. EXCEPTION: When the parent or guardian appeals the termination of benefits for a child who has attained the age of 18 or who will attain the age of 18 during the appeal, subsidy payments shall not be paid during the appeal after the child has turned 18. If there is a final decision in favor of the parent or legal guardian, subsidy payments shall be made consistent with the ruling.

These rules are intended to implement Iowa Code sections 225C.35 to 225C.42.

441—184.10 to **184.20** Reserved.

DIVISION II
COMPREHENSIVE FAMILY SUPPORT PROGRAM

PREAMBLE

The purpose of this division is to define and structure the comprehensive family support program, known as "children at home." This program is designed to assist families raising a child with a disability in obtaining needed services and supports. This program provides families with assistance in locating resources and with funding when other sources of support are not available. It is the intent of the legislature that families maintain control over decision making regarding what is best for their children. Services and support provided under the children at home program shall not be used to supplant other services and supports available to the family of an individual with disabilities but shall be used to meet family needs that would not be met without the program.

441—184.21(225C) Definitions.

"Comprehensive family support" means the array of services and supports that assist families who are caring for a family member with a disability. Services and supports include, but are not limited to, programs, services, parent-to-parent support, assistive devices, and various adaptations that allow children with disabilities to participate more fully in family and community life.

"Family" means a group of interdependent persons living in the same household. A family may consist of an individual with a disability and any of the following:

1. The individual's parent.
2. The individual's sibling.
3. The individual's grandparent, aunt, or uncle.
4. The individual's legal custodian.
5. A person who is providing short-term foster care to the individual subject to a case permanency plan that provides for reunification between the individual and the individual's parent.

"Family" does not include a person who is employed to provide services to an individual with a disability in an out-of-home setting, including but not limited to a hospital, nursing facility, personal care home, board and care home, group foster care home, or other institutional setting.

"Individual with a disability" means a person who is less than 22 years of age and meets the definition of developmental disability in 42 U.S.C. § 6001.

"Services and support" means services or other assistance intended to enable an individual with a disability to control the individual's environment, to remain living with the individual's family, to function more independently, and to integrate into the individual's community. Services and support may include, but are not limited to, funding for:

1. Purchase of equipment, respite care, supplies, or assistive technology; and
2. Payment of other costs attributable to the individual's disability that are identified by the individual's family.

441—184.22(225C) Eligibility. Eligibility for the children at home program is limited to families who meet all the following conditions:

184.22(1) The family resides in the state of Iowa.

184.22(2) The family includes an individual with a disability.

184.22(3) The family expresses an intent for the individual with a disability to remain living in the family's home.

184.22(4) The family's net taxable income in the most recently completed tax year is less than $60,000.

441—184.23(225C) Application. A family may apply to the department or to a local children at home contractor for assistance using Form 470-4399, Application for Children at Home Services. The local children at home contractor shall determine eligibility for services in accordance with the provisions of this division.

441—184.24(225C) Contractor selection and duties. Whenever possible, the department shall contract with local agencies to implement the children at home program.

184.24(1) *Selection.* Contractors shall be selected through competitive bidding and a demonstrated ability to provide disability-related services and supports.

184.24(2) *Duties.* The local children at home contractor shall agree to perform the following activities:

a. Provide a single entry point for applicants to learn about and connect with a variety of needed services and supports.

b. Assist families in identifying and applying for services they believe will help meet the needs of their family.

c. Develop and disseminate a brochure describing the services available.

d. Provide services and support in a timely manner.

e. Inform families of emergency access to needed services and support, as needed.

f. Survey parents annually to determine how the program is helping parents meet the needs of individuals with disabilities and include the survey results in the annual report to the department.

g. Submit quarterly and annual reports to the department. The reports shall contain:

(1) A summary of the number of applications and services provided;

(2) An unduplicated count of children and families served; and

(3) Any other items listed in the contract with the department.

441—184.25(225C) Direct assistance. Each local children at home contractor shall, with the advice and assistance of the parent advisory council described in rule 441—184.27(225C), develop procedures for providing direct financial assistance for supports and services that cannot be funded through other programs or means. Local policies shall be submitted to and approved by the department.

441—184.26(225C) Appeals. A process is available to appeal the department's or the local children at home contractor's decisions involving families that apply for the children at home program and are denied services and support under the program. Families, contractors, and the department shall follow the appeal procedures outlined in 441—Chapter 7.

441—184.27(225C) Parent advisory council. Each local children at home contractor shall establish a local advisory council of at least five members to advise the children at home program coordinator in developing local policies and procedures.

184.27(1) *Membership.* A majority of the advisory council members shall be parents of an individual with a disability. Other members shall be recruited from agencies and organizations that have expertise in serving families and children with special needs.

184.27(2) *Role.* The role of the council is to ensure that the views and best interests of individuals with disabilities and their families are represented in the policy discussions with the program coordinator. Council members may attend meetings of the comprehensive family support council established in Iowa Code section 225C.48 as amended by 2006 Iowa Acts, Senate File 2217, section 22. Final decisions regarding funding of specific requests are the responsibility of the contracting agency that is responsible for the children at home program.

These rules are intended to implement Iowa Code section 225C.47 as amended by 2006 Iowa Acts, Senate File 2217, division VI.

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CHAPTER 185
REHABILITATIVE TREATMENT SERVICES
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 186
COMMUNITY CARE

PREAMBLE

These rules define and structure community care services. Services are provided through a single statewide performance-based contract for the development and delivery of community care in all rural and urban areas of the state.

441—186.1(234) Definitions.

"Assessment" means the process by which the department responds to all accepted reports of alleged child abuse. An "assessment" addresses child safety, family functioning, culturally competent practice, and identifies the family strengths and needs, and engages the family in services if needed. The department's assessment process occurs either through a child abuse assessment or a family assessment.

"At risk" means that potential exists within the family for some level of child abuse or neglect.

"Child" means a person who is under 18 years of age.

"Child abuse assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(1) through (3) and (5) through (10); or which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) that also allege imminent danger, death, or injury to a child. A "child abuse assessment" results in a disposition and a determination of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the central abuse registry are met.

"Community care" means child- and family-focused services and supports provided to families referred from the department. Services shall be geared toward keeping the children in the family safe from abuse and neglect; keeping the family intact; preventing the need for further intervention by the department, including removal of the child from the home; and building ongoing linkages to community-based resources that improve the safety, health, stability, and well-being of families served.

"Confirmed" means the department has determined that a preponderance of credible evidence (greater than 50 percent) indicates that child abuse has occurred.

"Department" means the Iowa department of human services.

"Family" means the persons comprising the household where the alleged victim of child abuse resides.

"Founded" means the department has determined that a preponderance of credible evidence (greater than 50 percent) indicates that child abuse occurred and the circumstances meet the criteria for placement on the central abuse registry.

"Not confirmed" or *"unconfirmed"* means the department has determined that there is not a preponderance of credible evidence (greater than 50 percent) indicating that child abuse has occurred.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—186.2(234) Eligibility. A family's eligibility for community care is established by department referral to the community care contractor.

186.2(1) *Referral indicated.* The department will refer a family for community care when the following conditions exist:

a. A child abuse assessment has identified a need for community care and the child abuse assessment findings are one of the following:

(1) Abuse is not confirmed, but the child is believed to be at moderate to high risk of future abuse or neglect; or

(2) Abuse is confirmed but not founded, and the child is believed to be at moderate risk of future abuse or neglect.

b. A family assessment has identified a need for community care, and the child is believed to be at moderate to high risk of future abuse or neglect.

c. The family has voluntarily agreed to be referred to community care.

186.2(2) *Referral not indicated.* The department will not refer a family for community care when:

a. A child has been adjudicated a child in need of assistance or a child in need of assistance petition was filed or is pending. Court orders are not used as a mechanism for families to receive community care.

b. Any child in the household has an open child welfare service case with the department.

c. The abuse occurred in an out-of-home setting.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—186.3(234) Services provided. The department has a single contract for development and delivery of community care in all rural and urban areas of the state. The contractor shall meet the following expectations, either directly, through subcontract, or through a provider network or consortium.

186.3(1) The community care contractor shall serve families at risk of child abuse or neglect referred through the contract, including families from a wide range of cultural, racial, and ethnic groups and those with limited English proficiency.

186.3(2) The community care contractor shall assess individual child needs, family functioning, and potential child and family risk factors.

186.3(3) The community care contractor shall respond to the needs of community care families in crisis.

186.3(4) The community care contractor shall connect families to a wide range of community resources and services that are responsive to the families' presenting needs at the time of referral, in keeping with community standards of care and evidence-based research.

186.3(5) The community care contractor shall connect families to community resources and services that are responsive to the identified needs of the family.

186.3(6) The community care contractor shall have a service referral network that is readily accessible, available, and convenient to families in all areas served by the contract.

186.3(7) The community care contractor shall provide ongoing assessment of the services provided.

186.3(8) The community care contractor shall ensure coordination of referrals from the department's offices statewide.

186.3(9) The community care contractor shall monitor and document service utilization.

186.3(10) The community care contractor shall achieve minimum performance targets as specified in the contract.

441—186.4(234) Appeals. A person or family may appeal the decisions of a community care contractor only after exhausting the contractor's dispute resolution process, as outlined in the contract with the department for provision of community care. If it is verified that the contractor's dispute resolution process has been exhausted, a person or family who wants to appeal the decisions of a community care contractor may do so under the provisions of 441—Chapter 7.

These rules are intended to implement Iowa Code section 234.6 and 2003 Iowa Acts, chapter 178, section 44.

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CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care in their successful transition to adulthood. The aftercare program, including the preparation for adult living (PAL) component, helps former foster care youth to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program also offers financial benefits to eligible youth up to the age of 21. All services and supports are voluntary.

DIVISION I
AFTERCARE SERVICES

441—187.1(234) Purpose. The purpose of aftercare services is to provide services and supports to youth aged 18, 19 or 20 who were formerly in foster care. The primary goal of the program is for participants to achieve self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

441—187.2(234) Eligibility. To be eligible for aftercare services, a youth must meet the following requirements:

187.2(1) *Residence.* The youth must reside in Iowa.

187.2(2) *Age.* The youth must be at least 18 years of age but less than 21 years of age.

187.2(3) *Foster care experience.*

a. The youth must leave foster care:

(1) On or after the youth's eighteenth birthday; or

(2) Between the ages of 17½ and 18 after being in foster care continuously for at least six months; or

(3) For placement in a subsidized guardianship arrangement on or after October 7, 2008, and on or after the youth's sixteenth birthday; or

(4) Due to adoption on or after October 7, 2008, and on or after the youth's sixteenth birthday.

b. For purposes of this division, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either court order or voluntary agreement.

c. A placement may meet the definition of foster care regardless of whether:

(1) The placement is licensed and the state or a local agency makes payments for the child's care;

(2) Adoption subsidy payments are being made before the finalization of adoption; or

(3) There is federal matching of any payments made.

d. Foster care may include, but is not limited to, placement in:

(1) A foster family home;

(2) A foster home of relatives;

(3) A group home;

(4) An emergency shelter;

(5) A preadoptive home;

(6) A residential facility; or

(7) The home of an unlicensed relative or suitable person.

(8) A psychiatric medical institution for children (PMIC).

e. Foster care does not include placement in:

(1) A detention facility;

(2) A forestry camp;

(3) A training school; or

(4) Any other facility operated primarily for the detention of children who are determined to be delinquent.

187.2(4) *Responsibility.* The youth must:

a. Actively take part in developing and participating in a self-sufficiency plan; and

b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency.

[**ARC 8717B**, IAB 5/5/10, effective 7/1/10]

441—187.3(234) Services and supports provided. The aftercare program shall provide the following services and supports to eligible youth:

187.3(1) *Individual self-sufficiency plan.* Each youth shall have an individual self-sufficiency plan based on an assessment of the youth's strengths and needs. The plan shall identify:

a. The youth's goals for achieving self-sufficiency;

b. The target date for reaching the goals; and

c. The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

187.3(2) *Life skills services.* The program shall provide life skills services to enable youth to maintain a safe, healthy, and stable home.

187.3(3) *Vendor payments.* The program shall make vendor payments to meet direct expenses of the participant that are necessary in order to meet goals of the participant's self-sufficiency plan.

a. *Need.* To receive a vendor payment, the youth must demonstrate that there are no other means to meet these needs. Youth receiving a PAL stipend are not eligible for a vendor payment.

b. *Scope.* Vendor payments may include but are not limited to:

(1) Life skills training;

(2) Transportation assistance;

(3) Employment and education assistance;

(4) Clothing; and

(5) Room and board.

c. *Maximum payment.* The amount available for a 12-month period of service shall not exceed $1200 per youth.

187.3(4) *Follow-up.* The program shall maintain individual face-to-face contact with the youth at a frequency as defined in the youth's self-sufficiency plan to ensure that the youth is meeting the goals of the plan.

187.3(5) *Ongoing assessment.* Ongoing assessment activities shall be directed toward:

a. Monitoring the progress being made in the youth's ability to achieve self-sufficiency; and

b. Coordination and evaluation of the services and supports being provided to reach the self-sufficiency goal.

187.3(6) *Case management.* Case management activities shall include, but not be limited to:

a. Community involvement services to enable the youth to access community resources; and

b. Development of support systems, including services to assist the youth in establishing or reestablishing relationships with significant adults.

441—187.4(234) Termination. Aftercare services and supports shall be terminated when any of the following conditions apply:

187.4(1) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator.

187.4(2) The youth voluntarily withdraws from aftercare services.

187.4(3) The youth is no longer residing in Iowa.

187.4(4) The youth reaches 21 years of age.

187.4(5) There are insufficient funds to continue the services.

441—187.5(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.6(234) Administration. The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer this program.

187.6(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)*"i."*

187.6(2) Agencies providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

441—187.7 to **187.9** Reserved.

These rules are intended to implement Iowa Code section 234.6 and Public Law 106-169, the Foster Care Independence Act of 1999.

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

441—187.10(234) Purpose. The purpose of the PAL program is to provide financial support to eligible youth who are receiving aftercare services. Youth receiving a PAL stipend are not eligible to receive aftercare vendor payments.

441—187.11(234) Eligibility. A monthly stipend may be provided to a youth receiving aftercare services who left foster care after May 1, 2006, and who meets all of the following criteria:

187.11(1) *Ineligibility for foster care.* The youth must be ineligible for voluntary foster care placement under 441—Chapter 202.

187.11(2) *Foster care experience.* The youth must:

a. Leave foster care paid for by the state under Iowa Code section 234.35 on or after the youth's eighteenth birthday; and

b. Have been in foster care paid for by the state under Iowa Code section 234.35 in at least 6 of the last 12 months before the youth left foster care.

187.11(3) *Living arrangement.* The youth must have a living arrangement other than a parent's home, which may include a former foster family, an apartment, a college dormitory, or another approved arrangement. The program administrator or designee is responsible for approving the living arrangement.

187.11(4) *Activity.* The youth must meet one or more of the following criteria:

a. Be enrolled in or actively pursuing enrollment in a postsecondary education or training program or work training;

b. Be employed for 80 hours per month or be actively seeking that level of employment; or

c. Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or

d. Be attending an instructional program leading to a high school equivalency diploma.

187.11(5) *Financial need.* Initial and ongoing eligibility shall be based on the youth's income and need as determined according to rule 441—187.12(234).

[**ARC 8717B**, IAB 5/5/10, effective 7/1/10]

441—187.12(234) Payment. The program administrator or designee shall issue payment to each participant according to the following guidelines:

187.12(1) *Need.* The amount of the PAL stipend shall be based on the needs of the youth as documented in the youth's self-sufficiency plan. Eligibility and the stipend amount shall be based on the best estimate of the youth's income, as determined at least quarterly.

a. All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income.

(1) If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments include but are not limited to one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as SSI, unemployment insurance, or public assistance.

b. The youth shall timely report the beginning or ending of earned or unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

c. When the youth timely reports a change in income, prospective eligibility and stipend amount for the following month shall be determined based on the change.

d. Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment shall be done through a reasonable reduction of any future stipends.

e. Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—7.7(17A) requires that the action be delayed until the second calendar month following the month of change.

187.12(2) *Amount of monthly stipend.* The maximum monthly stipend shall be $602.70.

a. The stipend shall be prorated based on the date of entry.

b. Effect of income.

(1) When the monthly unearned income of the youth exceeds the maximum monthly stipend, the youth is not eligible for a stipend.

(2) When the net earnings of the youth exceed the maximum monthly stipend, the stipend shall be reduced the following month by 50 cents for every dollar earned over the maximum monthly stipend.

(3) A youth receiving Supplemental Security Income payments is not eligible for a stipend.

187.12(3) *Payee.* The PAL stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the self-sufficiency plan under 187.3(1).

187.12(4) *Start-up allowance.* When a youth is approved for the PAL program, the program administrator or designee may authorize a one-time start-up allowance in addition to the monthly stipend. The start-up allowance:

a. Is intended to assist in covering the initial costs of establishing the youth's living arrangement, such as rental and utility deposits, purchase of food, and purchase of necessary household items.

b. Shall be based on the youth's income and need as determined according to subrule 187.12(1).

c. Shall not exceed the maximum monthly stipend amount.

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8717B**, IAB 5/5/10, effective 7/1/10; **ARC 0851C**, IAB 7/24/13, effective 7/1/13; **ARC 1064C**, IAB 10/2/13, effective 11/6/13]

441—187.13(234) Termination of stipend. The PAL stipend shall be terminated when any of the following conditions apply:

187.13(1) The youth reaches the age of 21.

187.13(2) The youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

187.13(3) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator or designee.

187.13(4) The youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program by choosing the work option.

187.13(5) The youth chooses to live in a nonapproved setting.

187.13(6) The youth no longer resides in Iowa.

187.13(7) The youth lives with a parent.

187.13(8) There are insufficient funds to continue the stipend.

441—187.14(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the PAL program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.15(234) Administration. The department may contract with another state agency or a private organization to perform the administrative functions necessary to administer the PAL program.

187.15(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)*"i."*

187.15(2) Agencies providing support or services shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

These rules are intended to implement Iowa Code section 234.46.

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CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

[Prior to 7/1/83, Social Services[770] Ch 139]
[Previously appeared as Ch 139—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define and structure the adoption services to be provided to birth families, children legally available for adoption, prospective adoptive families and adoptive families. These rules also establish policy regarding requests for access to sealed records.

441—200.1(600) Definitions.

"Adoption" means a legal and social process through which a child becomes a member of a family into which the child was not born. Adoption provides the child the same rights, privileges and duties as a birth child.

"Adoption service" means a service directed towards children who are legally available for adoption, the birth family, prospective adoptive family and adoptive family.

"Adoption work experience" means supervised employment in adoption services which includes direct provision of adoption services, development of adoption policies, provision of training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. Only the percent of time related to provision of adoption services shall be considered as adoption work experience for employment of which only a portion of time was spent on adoptions.

"Adoptive family" means an approved person or persons who have a child placed in their home and are being supervised prior to finalizing the adoption; or who have a child in their home who is legally adopted and entitled to the same benefits as a child born into the family.

"Adoptive home study" includes an assessment of the family's parental attributes and a written report stating approval or nonapproval of the family for adoptive placement of a child or children.

"Certified adoption investigator" means a person as defined at rule 441—107.2(600).

"Child study or social history" includes a written description of the child including strengths and needs; medical, mental, social, educational, placement and court history; a description of the child's relationships with the birth family, foster family, and significant others; a summary of the child's understanding and feeling about adoption and recommendations as to the type of family that can best meet the child's needs.

"Court-ordered studies" means home studies ordered by a judge for the purpose of determining custody of a child or placement of a child for the purpose of adoption.

"Department" means the department of human services.

"Family safety, risk, and permanency service" means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

"Foster family adoption" means the adoption of a child by a licensed foster family who has cared for the child.

"Guardianship record" means a case record regarding a child, established and retained by the department, when the department is named guardian of the child by court order. The purpose of the guardianship record is to collect and maintain information about the child and the birth family, legal documents, and other information that will assist in fulfilling the responsibility of guardian.

"Life book" means a compilation of information about the child, including birth information, photographs of the child; placement history, including dates of placement, names of caretakers, reasons for leaving the placement; relationships; school reports; social, medical, mental health developmental

history; awards received, important events, letters from significant persons, and other information that the child wishes to include. The life book will assist the child in dealing with separation and loss issues and provide background and genealogy data.

"Mental health professional" means a psychiatrist, psychologist, social worker, psychiatric nurse or mental health counselor who holds a current license as required by law.

"Placement services" includes the activities and travel necessary to place the child in the adoptive family.

"Postadoption services" includes those services that an adoptive family may access after the adoption is finalized to assist the family in coping with and resolving problems within the family.

"Postplacement services" includes the supervision, support and intervention necessary prior to finalization to assist in maintaining the adoptive placement.

"Preadoptive family" means an approved adoptive family with a child placed in the home for adoption whose adoption has not been finalized.

"Preparation of child" includes activities necessary to ready the child for placement into an adoptive family.

"Preparation of family" includes the activities necessary to assist the family in adding an adoptive child as a new member of their family.

"Preplacement visits" means contacts, activities, and visits between the child and adoptive family prior to the adoptive placement.

"Procedendo" means an order issued by the supreme court returning jurisdiction to the district court after a final appellate decision regarding an appeal.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

"Relative within the fourth degree of consanguinity" means an adult who is related to a child as follows:

1. The child's parent, brother, or sister (first degree);
2. The child's grandparent, aunt, uncle, niece, nephew, or first cousin (second degree);
3. The child's great grandparent, great aunt, great uncle, great niece, great nephew, first cousin once removed, or second cousin (third degree); or
4. The child's great-great grandparent, great-grand aunt, great-grand uncle, great-grand niece, great-grand nephew, first cousin twice removed, second cousin once removed, or third cousin (fourth degree).

"Release of custody services" includes providing information regarding options to assist the parents in making permanent plans for their child and counseling regarding resulting personal and emotional issues.

"Selection of family" means reviewing approved home studies to match a family's strengths with a specific child's needs.

"Special needs child" means a child who meets one or more of the criteria set forth at 441—subrule 201.3(1).

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.2(600) Release of custody services. This rule applies to all terminations filed under Iowa Code chapter 600A. The parents shall be offered a minimum of three hours of counseling by a person authorized to provide counseling under the provisions of this rule. If accepted, the counseling shall be provided after the birth of the child and prior to the signing of a release of custody that meets the requirements of Iowa Code chapter 600A or prior to the filing of a petition for termination of parental rights.

200.2(1) *Purpose of counseling.* The purpose of the counseling is to:

a. Provide information about options to assist parents in making an informed decision regarding release of custody.

b. Assist parents in resolving emotional issues related to separation and loss.

200.2(2) *Requirements for counseling providers.* Counseling to parents shall be provided only by the following persons:

a. Certified adoption investigators.

b. Mental health professionals who have the equivalent of two years of adoption work experience in the direct provision of adoption services.

c. Private agency staff with two years of adoption work experience in the direct provision of adoption services.

d. Department staff with two years of adoption work experience in the direct provision of adoption services.

200.2(3) *Forms.* A child study shall be completed for all children who are adopted under Iowa Code chapter 600 using the outline RC-0027, Social History Format. All forms used to execute a release of custody shall comply with the requirements of Iowa Code chapters 600 and 600A.

200.2(4) *Affidavit and documentation.* The person providing the counseling shall complete Form 470-3164 or 470-3164(S), Counseling Affidavit, certifying that the counselor has provided the biological parent with the requested counseling or that the biological parent has refused counseling. The Counseling Affidavit and documentation that the person providing the counseling is qualified to provide the requested counseling shall be attached to the release of custody. Documentation shall include one of the following:

a. A copy of a professional license, when applicable.

b. A record of all adoption work experience including dates and location. In addition, the person providing counseling shall provide the names of employers and supervisors to enable the court to verify the counselor's adoption work experience.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.3(600) Application. Persons wishing to apply to adopt a child through the department shall use Form 470-0743 or 470-0743(S), Application for Adoption. An application for adoption shall only be accepted for children who are under the guardianship of the department.

200.3(1) *Limitations.* The department and its recruitment and retention contractor shall accept only applications for adoption of a special needs child. Applications for adoption of a child without special needs shall be referred to private child-placing agencies. Exceptions to this rule may be made for:

a. Relatives of a child under the guardianship of the department; or

b. Foster parents with whom the child has a significant relationship.

200.3(2) *Procedures.* An application for a special needs child shall be accepted by any department office or by the department's recruitment and retention contractor. Before a home study is completed, applicants shall:

a. Complete Form 470-0743 or 470-0743(S), Application for Adoption, and

b. Ensure that Form 470-0720, Physician's Report for Foster and Adoptive Parents, is completed by the applicant's family physician.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.4(600) Adoption services. Adoption services shall include: adoptive home study, preparation of child, selection of family, preparation of family, preplacement visits, placement services, and postplacement services.

200.4(1) *Adoptive home study.* The recruitment and retention contractor shall prepare an adoptive home study through the following activities:

a. *Family assessment.* The family assessment shall include a minimum of two face-to-face interviews with the applicants and at least one face-to-face interview with each member of the household. At least one of the interviews shall take place at the applicant's home. The assessment of the prospective adoptive family shall include an evaluation of the family's ability to parent a special needs child or children including the following:

(1) Motivation for adoption and whether the family has biological, adopted or foster children.

(2) Family's and extended family's attitude toward accepting an adopted child and plans for discussing adoption with the child.

(3) The attitude toward adoption of the significant other people involved with the family.

(4) Emotional stability, marital history, including verification of marriages and divorces, family relationships and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation, and loss.

(6) Medical, mental and emotional conditions that may affect the applicant's ability to parent a child, treatment history, and current status of treatment.

(7) Willingness to accept a child who has medical problems (such as a child who is at risk of, or is HIV positive), mental retardation, or emotional or behavioral problems. Ability to provide for the child's physical, medical and emotional needs and respect the child's ethnic and religious identity.

(8) Adjustment of any children in the home, including their attitudes toward adoption, relationships with others, and school performance.

(9) Disciplinary practices that will be used.

(10) Capacity to give and receive affection.

(11) Statements from three references provided by the family and additional references the worker may wish to contact.

(12) Financial information, ability to provide for a child and whether there is a need for adoption subsidy for a special needs child or children.

(13) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(14) Commitment to and capacity to maintain significant relationships.

(15) Substance use or abuse, if any, by family members, or members of the household, treatment history and current status of treatment.

(16) History of abuse, if any, by family members, or members of the household, treatment history, current status of treatment and the evaluation of the abuse.

(17) Criminal convictions, if any, by family members, or adults in the household, and the evaluation of the criminal record.

(18) Recommendations for number, age, sex, characteristics, and special needs of a child or children the family can best parent.

b. *Record checks.* Record checks are required for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The department's contractor for the recruitment and retention of resource families shall assist applicants applying through the department in completing required record checks, including fingerprinting.

(1) Iowa records. Each applicant and anyone who is 14 years of age or older living in the home of the applicant shall be checked for records with:

1. The Iowa central abuse registry, using Form 470-0643, Request for Child Abuse Information;

2. The Iowa division of criminal investigation, using Form 595-1396, DHS Criminal History Record Check, Form B; and

3. The Iowa sex offender registry.

(2) Other states' records. Each applicant and any other adult living in the applicant's home shall be checked for records on the child abuse registry of any state where the person has lived during the past five years.

(3) Federal records. Each applicant shall be fingerprinted for a national criminal history check. Other adults living in the home may be fingerprinted if the department determines that a national criminal history check is warranted.

(4) If the applicant, or anyone living in the home of the applicant, has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the department shall not approve the applicant as an adoptive family, unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval. The evaluation shall be conducted according to procedures in 441—subrules 113.13(2) and 113.13(3) for applications for adoption through the department or procedures in 441—subrule 108.9(4) for applications for adoption through a child-placing agency.

(5) The department shall assess fees associated with the record checks to the adoptive applicant unless the family is being studied to adopt a child with special needs.

c. *Written report.* The worker shall prepare a written report of the family assessment, known as the adoptive home study, using the PS-MAPP family profile format. The worker shall use the home study to approve or deny a prospective family as an appropriate placement for a child or children. The department adoption worker and supervisor shall date and sign the adoptive home study.

The worker shall notify the family of the decision using Form 470-0745, Adoption Notice of Decision, and, if the worker does not approve the home study, shall state the reasons on the notice. The worker shall provide the family a copy of the adoptive home study with the notification of approval or denial.

d. *Preplacement assessment and home study update.* A preplacement assessment and home study update is required if the adoptive home study was written more than one year previously, in accordance with Iowa Code section 600.8, and placement of the child is imminent. The preplacement assessment and home study update shall be conducted by completing the following:

(1) The child abuse and criminal record checks shall be repeated, except for fingerprinting. If there are any founded abuses or convictions of crimes that were not evaluated in the previous home study, they shall be evaluated using the process set forth in 200.4(1)*"b."*

(2) One face-to-face visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) An updated written report of the reassessment and adoptive home study shall be written, dated, signed by the worker and the supervisor; and a copy provided to the adoptive family.

e. *Procedure for foster parent adoptions.* When a licensed foster parent applies for approval as an adoptive home, home study activities that have been completed within the previous year as part of a licensing study pursuant to 441—Chapter 113 need not be repeated.

200.4(2) *Preparation of child.* The department adoption worker shall conduct specific activities designed to enable a child to make the transition to an adoptive placement or refer the child to the family safety, risk, and permanency services contractor or other professionals. The activities shall include, but are not limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Preparation or update of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support groups, to assist the child in the transition and integration into the adoptive family.

d. Any appropriate evaluations or testing.

e. HIV testing of a child by the University of Iowa Hospital or a local physician when any of the following conditions exist:

(1) The child was, or may have been, sexually abused by a person who participated in high-risk behavior such as sharing of needles with an infected person or sex participation with an infected person.

(2) The child's birth mother participated in high-risk behavior, or is HIV positive.

(3) The child participated in, or has participated in**,** high-risk behavior.

(4) The child is symptomatic or at high risk of infections.

(5) The child received blood products prior to 1986 or the birth parents received blood products prior to 1986, before or during pregnancy.

(6) There is a lack of medical information regarding the birth parents or the child.

200.4(3) *Selection of family.* The family that can best meet the needs of the adoptive child shall be selected as follows:

a. Before preplacement visits occur, a conference shall be held to select an approved family. A minimum of two social workers and a supervisor shall be included in the conference. The child's special needs, characteristics, and anticipated behaviors shall be reviewed in the conference to determine a family that can best meet the needs of the child. Approved families shall also be reviewed in an effort to match the specific family's parenting strengths with a particular child's needs.

b. The following selection criteria shall be observed:

(1) Preference shall be given to placing children from the same birth family together. If placement together is not possible, or is not in the best interest of the children, the reasons shall be identified and

documented in each child's case record. Efforts shall be made to ensure continuous contact between siblings when the siblings are not placed together.

(2) Race, color, or national origin may not be routinely considered in placement selections except when an Indian child is being placed pursuant to Iowa Code section 232.7 or Iowa Code chapter 232B. Placement decisions shall be made consistent with the best interests and special needs of the child.

(3) A relative who is within the fourth degree of consanguinity shall be given consideration for selection as the adoptive family for a child who is legally available for adoption if the child has a significant relationship with the relative or the child is aged 14 or older and elects adoption by the relative.

(4) Foster parents shall be given consideration for selection as the adoptive family for a child in the foster parents' care who is legally available for adoption if the child has been in the foster parents' care for six months or longer or the child has a significant relationship with the family.

200.4(4) *Preparation of family.* The recruitment and retention contractor and the department adoption worker shall conduct activities designed to assist the adoptive family in expanding its knowledge and understanding of the child or children. These activities should enhance the family's readiness to accept the child or children into their family and encourage their commitment. A referral may be made for family safety, risk, and permanency services if needed. The activities shall include, but are not limited to:

a. Completion of at least 30 hours of "Partnering for Safety and Permanence: Model Approach to Partnership in Parenting" (PS-MAPP) and the self-study course, "Universal Precautions in Foster and Adoptive Family Homes," before placement of a child. These training requirements apply to families who are adopting special needs children who are under the guardianship of the department.

(1) Foster parents licensed before December 31, 2002, who have been caring for a foster child in their home for at least six months and who have been selected to adopt that child may have their participation in adoption training waived by the service area manager or designee.

(2) Relatives who have cared for a related child for at least six months and who have been selected to adopt that related child may have their participation in the PS-MAPP preservice training waived by the service area manager or designee.

(3) The department may waive the PS-MAPP training requirement in whole or in part when the department finds that:

1. The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

2. There is good cause for the waiver based upon the circumstances of the child and the applicant.

(4) If the adoptive parents are accepting placement of a child who is at high risk of becoming or is HIV positive, they shall also complete the "Caring for Children With HIV" course.

(5) Applicants must retake PS-MAPP if the adoption approval process is not completed within 24 months after PS-MAPP is initially completed.

b. Discussion with family members regarding problems resulting from a child's separation, loss, grief, and anger due to the loss of the birth parents.

c. Provision of background information on the child and birth family, including a child study that includes experiences such as foster and adoption placements and other pertinent information and the child's life book.

d. Provision of information regarding the child's special needs and behavior patterns.

e. Provision of a description of the child's medical needs, including whether or not the child is at risk of or is HIV positive.

f. Discussion of the impact that adding a new member or members to the family may have on all current family members.

g. Explanation of the subsidized adoption program.

h. Provision of information regarding the community resources that are available to assist the family, such as parent support groups.

200.4(5) *Preplacement visits.* The department worker shall plan, conduct and assess the transitional visits between the adoptive family and the child or children before the adoptive placement of the child in the home.

200.4(6) *Placement services.* Placement services include the activities necessary to plan and carry out the placement of a child or children into the adoptive family.

Before placement of a child, the Agreement of Placement for Adoption, Form 470-0761, shall be signed by all parties.

200.4(7) *Postplacement services.* An adoptive family is eligible for postplacement services from the time a child is placed with the family until finalization of the adoption occurs. The department adoption worker shall supervise the placement, provide ongoing support to the child and family, perform crisis intervention, and complete required reports. Assistance with behavioral interventions to strengthen the placement and prevent disruption may be provided through family safety, risk, and permanency services.

a. Postplacement supervision shall focus on the following areas:

(1) Integration and interaction of the child or children with the family.

(2) Changes in the family functioning which may be due to the placement.

(3) Social and emotional adjustment of the child or children.

(4) School adjustment of the child or children who are attending school.

(5) Changes and adjustments that have been made in the family since the placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Child's growth and development since placement in the family.

(8) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

b. At a minimum, the department adoption worker shall make monthly adoptive home visits until the adoption is final. If the family is experiencing problems, the worker shall make as many visits as are necessary to assess and support the placement.

c. The department adoption worker shall prepare a written report based on the postplacement visits with recommendations regarding the finalization of the adoption and submit the report to the court before the hearing to consider granting a decree of adoption.

200.4(8) *Postadoption services.* The department's recruitment and retention contractor shall provide postadoption services to families that are eligible for the department's adoption subsidy program in accordance with the contract. The goal of these services is to prevent adoption dissolution. The family may obtain additional support through community resources or support groups.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.5(600) Termination of parental rights. The department shall not place a child in an approved adoptive home until parental rights of the child's birth parents have been terminated and guardianship assigned to the department. If one or both birth parents are deceased, the worker shall provide the court with verification of the birth parents' death and the death shall be stated in the guardianship order. When the termination of parental rights is appealed by a birth parent, an adoptive placement may be made if the adoptive parents sign an adoptive placement agreement that includes an acknowledgment of the conditions of the placement should termination be overturned. However, the adoption may not be finalized until the appeal is withdrawn or a final decision regarding the appeal is reached and a procedendo issued.

441—200.6(600) Service provision. Rescinded IAB 7/29/09, effective 10/1/09.

441—200.7(600) Department fees. Rescinded IAB 7/29/09, effective 10/1/09.

441—200.8(600) Interstate placements. Interstate placement of a child into Iowa, or out of Iowa, shall follow interstate placement of child procedures according to Iowa Code section 238.33.

441—200.9(600) International adoptions. Rescinded IAB 7/29/09, effective 10/1/09.

441—200.10(600) Requests for home studies.

200.10(1) *Court-ordered.* Court-ordered home studies for adoption of a child or children under the authority of the department shall be completed by the department's recruitment and retention contractor.

200.10(2) *Interstate compact.* Requests for an adoptive home study through the interstate compact process shall be completed by the department's recruitment and retention contractor.
[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.11(600) Reasons for denial. An individual or family shall be denied approval of an adoptive home study for one or more of the following reasons:

200.11(1) *Founded child abuse report.* A founded child abuse report shall mean denial of approval unless an evaluation determines than it does not merit denial.

200.11(2) *Criminal conviction.* A criminal conviction shall mean denial of approval unless an evaluation determines that it does not merit denial.

200.11(3) *Documented concerns.* Concerns may be documented in one or more of the following areas:

a. Motivation to adopt.
b. Child-rearing ability and practices.
c. Emotional stability.
d. Physical or mental health.
e. Interpersonal relationships.
f. Finances.
g. Marital relationship.

200.11(4) *Substance abuse.* Verified substance use or abuse that prevents the family from adequately caring for the child shall mean denial of approval.

200.11(5) *Lack of cooperation.* If the individual or family fails to cooperate in providing the information needed to complete the preplacement assessment or home study, the application shall be denied.

441—200.12(600) Removal of child from preadoptive family. When the department determines that it is in the best interest of a child to be removed from a preadoptive family, a Letter of Removal, Form 470-3018, shall be mailed to the family prior to the removal. Removal of a child from a preadoptive family is not an appealable issue, as a child continues to be under the guardianship of the department until an adoption is finalized.

441—200.13(600) Consents. A request for consent to the adoption shall be submitted to the guardian for a child who is under the guardianship of the department and for whom finalizing an adoption is recommended. If the adoption is in the best interest of the child, the director or designee shall sign a Consent to Adoption, Form 470-0775, prior to a court hearing to finalize the adoption.

A consent to adopt may be rescinded by the department, by signing Rescinding the Consent to Adoption, Form 470-2990, for any of the following reasons:

1. At the request of the adoptive family.
2. A founded child abuse report, or accusation of child abuse, pending determination of the report.
3. Conviction of a crime, or accusation of a crime, pending a court decision regarding the crime.
4. At the request of a child who is aged 14 or over and has reversed the decision regarding the adoption.
5. Other verified indications that the adoption is not in the best interest of the child.

441—200.14(600) Requests for access to information for research or treatment.

200.14(1) *Requests.* Any person seeking access to the department's sealed adoption records for the purpose or purposes set forth in Iowa Code paragraph 600.16(1)*"c"* or Iowa Code subsection 600.24(2) shall submit a request in writing to the director. Each request shall contain sufficient facts to establish that the information sought is necessary for conducting a legitimate medical research project, or for treating a patient in a medical facility.

200.14(2) *Process.* Upon receipt of a request for information sought in conducting a research project, the director or a designee shall review the request for information and make a decision to approve, or deny, the request based on the research to be conducted, the benefits of the research, the methodology,

and the confidentiality measures to be followed. Upon a request for information for treating a patient in a medical facility, a decision regarding approval or denial shall be made by the director or designee based on the written information provided by a physician or the medical facility, making the request. Requesters shall be notified in writing of approval or denial and if denied, reasons for denial given.

441—200.15(600) Requests for information for purposes other than research or treatment. Requests for information from department adoption records for purposes other than research or treatment shall be made to the Department of Human Services, Division of Child and Family Services, Adoption Program, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

200.15(1) The department shall not release identifying information from sealed adoption records. Adult adoptees, adoptive parents, birth parents, siblings or descendants of an adopted person, or legal representatives of any of the above shall be provided:

a. An adoption packet containing a sample affidavit for filing with the court,

b. Directions for filing the affidavit,

c. A list of county clerks of court,

d. The address of the bureau of vital statistics, and

e. Instructions on how to obtain the name of the Iowa county where the adoption was finalized, if necessary.

200.15(2) An adopted person who was a resident of the Annie Wittenmeyer Home (Iowa Soldier's and Sailor's Home) may receive nonidentifying information from Annie Wittenmeyer records if the information is available.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—200.16(600) Appeals. Prospective adoptive families may appeal denial of approval of their home study based on rule 441—200.11(600), pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 600.

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CHAPTER 201
SUBSIDIZED ADOPTIONS

[Prior to 7/1/83, Social Services(770), Ch 138]
[Previously appeared as Ch 138—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services(498)]

441—201.1(600) Administration. The Iowa department of human services, through the administrator of the division of child and family services, shall administer the subsidized adoption program, in conformance with the legal requirements for adoption as defined in Iowa Code chapter 600.

441—201.2(600) Definitions.

"Child" means a person who has not attained age 18, or a person with a physical or mental disability who has not attained age 21.

"Escrow account" means an interest-bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

"Maintenance subsidy" means a monthly payment to assist in covering the cost of room, board, clothing, and spending money. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

"Mental health professional" means the same as defined in rule 441—24.1(225C).

"Mental retardation professional" means a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. A person who holds at least a bachelor's degree in a human services field including, but not limited to: social work, sociology, special education, rehabilitation counseling, and psychology.

"Nonrecurring expenses" means reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are directly related to the legal adoption of a child with special needs. These shall be limited to attorney fees, court filing fees and other court costs.

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Presubsidy" means payment for maintenance or special services for a special needs child who is placed in an adoptive home but whose adoption is not finalized.

"Special services subsidy" means payment to a provider or the parent for medical, dental, therapeutic, or other services, equipment or appliances required by a child because of a handicapping condition.

441—201.3(600) Conditions of eligibility or ineligibility.

201.3(1) The child is eligible for subsidy when the department or a private agency has documented that it has been unable to place the child in an appropriate adoptive home without a subsidy and the child is determined to be a child with "special needs" based on one or more of the following reasons:

a. The child has a medically diagnosed disability which substantially limits one or more major life activities, requires professional treatment, assistance in self-care, or the purchase of special equipment.

b. The child has been determined by a qualified mental retardation professional to be mentally retarded.

c. Effective April 20, 2004, or later, the child has been determined by a qualified professional to be at high risk of developing a qualifying medical, mental, or emotional condition as defined in this subrule. A child in this group is eligible for subsidy of nonrecurring expenses only.

d. The child has been diagnosed by a qualified mental health professional to have a psychiatric condition which impairs the child's mental, intellectual, or social functioning, and for which the child requires professional services.

e. The child has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially

from behavior appropriate to the child's age or significantly interferes with the child's intellectual, social and personal adjustment.

f. The child is aged eight or over and Caucasian.

g. The child is aged two or older and is a member of a minority race or ethnic group or the child's biological parents are of different races.

h. The child is a member of a sibling group of three or more who are placed in the same adoptive home.

201.3(2) A child who enters the United States from another country on the basis of a visa classifying the child as an orphan, in accordance with the Immigration and Naturalization Act, for the purpose of adoption by a specific United States family is not eligible for subsidized adoption maintenance payments, medical assistance, or special services except for nonrecurring expenses. A child entering the country for adoption may be eligible for subsidy for nonrecurring expenses, not to exceed $500, in the following situations:

a. Rescinded IAB 8/11/99, effective 10/1/99.

b. The child from another country who meets the criteria in subrule 201.3(1) and whose adoption is finalized after June 14, 1989, must file an application on Form 470-0744, Application for Adoption Subsidy, and complete Form 470-0749, Adoption Subsidy Agreement, before or at the time of a final decree of adoption. The claim for reimbursement must be filed on Form GAX, General Accounting Expenditure, within two years of the date of the adoption decree and must include receipts.

c. If the adoptive placement disrupts prior to finalization or if the parental rights of the adoptive parents are terminated after the adoption is finalized and the department is named guardian of the child, the child may be eligible for subsidy in another adoptive placement.

201.3(3) Maintenance and child care subsidies for children who were determined to be eligible before January 1, 2004, shall continue unless one of the conditions for termination defined in 441—201.7(600) is present. The child care subsidy payment shall not exceed the applicable reimbursement rate under the child care assistance program as specified in 441—subrule 170.4(7).

201.3(4) The determination of whether a child meets eligibility requirements is made by the Iowa department of human services. An adverse determination may be appealed according to rules in 441—Chapter 7.

201.3(5) The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive a subsidy through the age of 21 due to the child's physical or mental disability.

a. The disability shall be diagnosed by a physician, a qualified mental health professional, or a qualified mental retardation professional.

b. The diagnosis shall be current within one year of the child's eighteenth birthday.

441—201.4(600) Application. Application for presubsidy or subsidy shall be made on Form 470-0744, Application for Subsidy, at the time of the adoptive placement of the child, or at any time in the adoptive process before finalization of the adoption.

201.4(1) The prospective adoptive family residing in Iowa who has been studied and approved for adoptive placement or a family residing outside of the state of Iowa studied and approved by a governmental child-placing agency or a licensed child-placing agency in that state, may apply for subsidy for an eligible Iowa child.

201.4(2) Withdrawal of the application for the subsidy shall be reported to the department immediately.

201.4(3) The effective date for the Adoption Subsidy Agreement will be the date the agreement is signed by all parties, which may be the date the child is placed in the adoptive home or any date up to and including the date the adoption is finalized. The agreement shall state the amount of the presubsidy or subsidy, and the frequency and duration of payments.

201.4(4) An application for subsidy cannot be taken after the child is adopted except when there are facts relevant to a child's eligibility that were not presented before the finalizing of the adoption.

a. Upon receiving verification that the child was eligible before the child's adoption, the department may conduct an administrative review of the facts and may determine the child an eligible special needs child. Eligibility will be effective after Form 470-0744, Application for Subsidy, is completed and Form 470-0749, Adoption Subsidy Agreement, is signed by all parties.

b. Requests for determining a child an eligible special needs child after the adoption is finalized shall be forwarded with verification of eligibility to the division of child and family services, adoption program. The division shall conduct an administrative review of eligibility factors and render a written decision regarding the child's eligibility as a special needs child within 30 days of receipt of request and verification materials unless additional verification is requested. If additional verification is requested, a decision shall be reached within 30 days of receipt of additional verification materials.

441—201.5(600) Negotiation of amount of presubsidy or subsidy.

201.5(1) The amount of presubsidy or subsidy shall be negotiated between the department and the adoptive parents and shall be based upon the needs of the child and the circumstances of the family.

a. Each time negotiations are completed, the Adoption Subsidy Agreement, Form 470-0749, shall be completed.

b. Form 470-0762, Agreement to Future Adoption Subsidy, shall be completed and retained in an inactive case record for future reference when:

(1) A child is eligible for subsidy but the child or family does not currently need assistance; or

(2) The child is at risk of being determined a child with special needs according to paragraph 201.3(1)*"a," "b," "d,"* or *"e"* in the future.

201.5(2) Other services available to the family free of charge to meet the needs of the child, such as other federal, state, and local governmental and private assistance programs, shall be explored and used before the expenditure of subsidy funds.

a. and *b.* Rescinded IAB 5/11/05, effective 5/1/05.

c. Unearned income of the child shall be verified by documentation provided to the department worker by the family from the source of the income.

201.5(3) to **201.5(5)** Rescinded IAB 5/3/89, effective 7/1/89.

201.5(6) A maintenance subsidy may be no less than $10 per month.

201.5(7) An adoptive family may request a review of the subsidy agreement when there is a change in the family's circumstances or the needs of the child.

201.5(8) Maintenance subsidy shall continue under the same rules if the adoptive family moves outside of the state of Iowa.

201.5(9) The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found at 441—subrule 156.6(1) and 441—paragraph 156.6(4)*"f."*

441—201.6(600) Types of subsidy.

201.6(1) *Special services only.*

a. Reimbursement to the adoptive family or direct payment made to a provider is suspended from January 1, 2010, to June 30, 2010, for any special services negotiated in that period except for nonrecurring expenses as defined in subparagraph (7).

(1) Outpatient counseling or therapy services. Reimbursement for outpatient individual or family services may be provided from a non-Medicaid provider only with approval from the service area manager or designee and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were already receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adoptive, or blended families.

Reimbursement to non-Medicaid providers shall be limited to the Medicaid rate.

(2) Expenses for transportation, lodging, or per diem related to preplacement visits, not to exceed $2000 per family.

(3) Medical services not covered by the Medicaid program shall be limited to an additional premium amount due to the child's special needs to include the child in the family's health insurance coverage group. An adoption subsidy payment shall not supplement the Medicaid payment rate to a Medicaid provider or a non-Medicaid provider.

(4) Child care, if the family has entered into a presubsidy or subsidy agreement on or before June 30, 2004, that contains a provision for child care reimbursement. Child care subsidy payments shall not exceed the maximum rates established in 441—paragraph 170.4(7)*"a"* for the child's age and type of care, unless the department grants a waiver under rule 441—1.8(17A,217). Child care services are available through the child care assistance program to families that meet the requirements of 441—Chapter 170.

(5) Medical transportation not covered by Medicaid and the family's lodging and meals, if necessary, when the child is receiving specialized care or the child and family are required to stay overnight as part of a treatment plan.

(6) Supplies and equipment as required by the child's special needs and unavailable through other resources. When a sibling group of three or more are placed together, a one-time-only payment can be made, not to exceed $500 per child. When home modifications have been authorized to accommodate a child's special needs and the family later sells the house, the family shall repay the department an amount equal to the increase in the equity value of the home attributable to the modifications.

(7) Nonrecurring expenses. Payment for nonrecurring expenses is generally limited to a total of $500 per child for attorney fees, court costs and other related legal expenses. Nonrecurring expenses may be paid when the adoptive family has negotiated an Adoption Subsidy Agreement, Form 470-0747, or an Agreement to Future Adoption Subsidy, Form 470-0762.

(8) Funeral benefits at the amount allowed for a foster child in accordance with 441—subrule 156.8(5).

b. The need for special services shall be established by a report in the child's record from the private or public agency which had guardianship of the child, and substantiating information from specialists as defined in rule 441—201.2(600).

c. Any single special service and any special service delivered over a 12-month period costing $500 or more shall have prior approval from the central office adoption program manager prior to expending program funds.

d. For all Medicaid covered services the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

201.6(2) *Maintenance only.* A monthly payment to assist with room, board, clothing and spending money may be provided, as determined under rule 441—201.5(600). The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

201.6(3) *Maintenance and special services.* For special needs children, a special services subsidy may also be included when a maintenance subsidy is provided.

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—201.7(600) Termination of subsidy. Subsidy will terminate when any of the following occur:

201.7(1) The adoptive child no longer meets the definition of child in rule 441—201.1(600).

201.7(2) The child marries.

201.7(3) The adoptive parents are no longer using the maintenance payments to support the child.

201.7(4) Death of the child, or death of the parents of the child (one in a single-parent family and both in a two-parent family).

201.7(5) Upon conclusion of the terms of the agreement.

201.7(6) Upon request of the adoptive parents.

201.7(7) The adoptive parents are no longer legally responsible for the child.

201.7(8) Rescinded IAB 3/12/08, effective 4/16/08.

441—201.8(600) Reinstatement of subsidy. Reinstatement of subsidy will be made when the subsidy was terminated because of reasons in 201.7(3), 201.7(6), or 201.7(7) and the reason for termination no longer exists.

441—201.9(600) New application. New applications will be taken at any time, but processed only so long as funds are available. Maintenance and special services already approved will continue.

441—201.10(600) Medical assistance based on residency. Special needs children eligible for any type of subsidy are entitled to medical assistance as defined in 441—Chapter 75. The funding source for medical assistance is based on the following criteria:

201.10(1) IV-E-eligible children:

a. IV-E-eligible children residing in Iowa from Iowa and from other states shall receive medical assistance from Iowa.

b. IV-E-eligible children from Iowa residing in another state shall receive medical assistance from the family's state of residence, even though medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

201.10(2) Non-IV-E-eligible children:

a. Non-IV-E-eligible children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Non-IV-E-eligible children from Iowa residing in another state shall be covered by Iowa's medical assistance unless eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act.

c. Non-IV-E-eligible children from another state residing in Iowa shall be covered by Iowa's medical assistance if all of the following conditions are met:

(1) The child is under the age of 21.

(2) The child is residing in Iowa in a private home with the child's adoptive parent or parents.

(3) Another state is currently paying an adoption subsidy for the child pursuant to an adoption assistance agreement in effect for the chid with that state.

(4) The state paying the adoption subsidy is a member of the interstate compact on adoption and medical assistance (ICAMA).

(5) The state paying the adoption subsidy provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

201.10(3) When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the family. An exception shall be made when the initial Iowa subsidy agreement provides for services not covered by the other states.

441—201.11(600) Presubsidy recovery. The department shall recover the cost of presubsidy maintenance and special services provided by the department as follows:

201.11(1) Funds shall be applied to the cost of presubsidy maintenance and special services from the unearned income of the child.

201.11(2) The department shall serve as payee to receive the child's unearned income. The income shall be placed in an account from whence it shall be applied toward the cost of the child's current care and the remainder placed in an escrow account.

201.11(3) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the presubsidy payments and not prohibited by the source of the funds.

201.11(4) When the child leaves presubsidy care, funds in the escrow shall be paid to the adoptive parents, or to the child if the child has attained the age of majority.

These rules are intended to implement Iowa Code sections 600.17 to 600.23.

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CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

[Prior to 7/1/83, Social Services[770] Ch 136]
[Previously appeared as Ch 136—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—202.1(234) Definitions.

"Case permanency plan" shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved and reviewing progress.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Department" shall mean the Iowa department of human services and includes the local offices of the department.

"Eligible child" shall mean a child for whom the court has given guardianship to the department or has transferred legal custody to the department or for whom the department has agreed to provide foster care services on the basis of a signed placement agreement or who has been placed in emergency care for a period of not more than 30 days upon the approval of the director or the director's designee.

"Facility" means the personnel, program, plant and equipment of a person or agency providing child foster care.

"Family safety, risk, and permanency service" means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

"Foster care" shall mean substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision, and health care.

"Natural parent" shall mean a parent by blood, marriage, or adoption.

"Person" or *"agency"* shall mean individuals, institutions, partnerships, voluntary associations, and corporations, other than institutions under the management or control of the department, who are licensed by the department as a foster family home, child caring agency or child placing agency, or approved as a shelter care facility.

"Resource family" means an individual person or married couple who is licensed to provide foster family care or approved for adoption.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Service area manager" shall mean the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social history" or *"child study"* means a written description of the child that includes strengths and needs; medical, mental, social, educational, placement and court history; and the child's relationships with the birth family and significant others.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.2(234) Eligibility.

202.2(1) Only an eligible child as defined in these rules shall be considered for foster care services supervised by the department.

202.2(2) The need for foster care placement and social and other related services, including but not limited to medical, psychiatric, psychological, and educational services, shall be determined by an assessment of the child and family to determine their needs and the appropriateness of services.

a. Assessments shall include:

(1) The educational, physical, psychological, social, family living, and recreational needs of the child,

(2) The family's ability to meet those needs, and

(3) A family genogram to determine relatives and other suitable support persons who have a kinship bond with the child.

b. The assessment is a continual process to identify needed changes in service or placement for the child.

202.2(3) With the exception of emergency care, a social history shall be completed on each child before a department recommendation for foster care placement, using the outline RC-0027, Social History Format.

a. For voluntary emergency placements, a social history shall be completed before a decision is made to extend the placement beyond 30 days.

b. For court-ordered emergency placements, a social history shall be completed before the disposition hearing.

202.2(4) Foster care placement shall be recommended by the department only after efforts have been made to prevent or eliminate the need for removal of the child from the family unless the child is in immediate danger at home.

202.2(5) The need for foster care and the efforts to prevent placement shall be evaluated by a review committee prior to placement or, for emergency placements only, within 30 days after the date of placement. For children who are mentally retarded or developmentally disabled and receive case management services, this requirement may be met by the interdisciplinary staffing described in 441—Chapter 90, as long as the service area manager approves, the department worker attends the staffing, and the staffing meets the requirements of paragraphs *"b"* to *"h"* below.

The review shall meet the following requirements:

a. Department staff on the review committee shall be the child's service worker, a supervisor knowledgeable in child welfare, and one or more additional persons appointed by the service area manager.

b. The review shall be open to the participation of the parents or guardian of the child, local and area education staff, juvenile court staff, the guardian ad litem, current service providers and previous service providers who have maintained a license.

c. The present foster care provider, if any, shall be notified of the review and have the opportunity to participate.

d. Written notice of the review shall be sent to the child's parents or guardian at least five working days prior to the date of the review.

e. Other persons may be invited to the review with the consent of the parents or guardian.

f. A written summary of the review recommendations shall be sent to the child's parents or guardian following the review.

g. Review committee recommendations shall be advisory to the service worker and supervisor, who are responsible for development of the department case plan and for reports and recommendations to the juvenile court.

h. At least one of the persons on the review committee shall be someone without responsibility for the case management or the delivery of services to either the child or the parents or guardian who are the subject of the review.

202.2(6) The citizenship or alien status of a child who enters foster care must be verified.

a. When the child will remain in foster care for no more than 60 days, Form 470-4500, Statement of Citizenship Status: Foster Care, signed by the parent or guardian of the child is sufficient.

b. When the child will remain in foster care for more than 60 days, one of the documents listed in this paragraph is required. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A certificate of birth in the United States.

(2) Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

(3) Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

(4) A United States passport.

(5) Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

(6) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(7) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(8) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(9) Another document that provides proof of United States citizenship or nationality as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v) or 1396b(x)(3)(C)(v).

c. A child entering foster care is exempt from these requirements when the family has previously presented satisfactory documentary evidence of citizenship, as specified by the Secretary of the U.S. Department of Health and Human Services.

d. The parent or guardian of the child shall have a reasonable period to obtain and provide proof of citizenship. For the purposes of this requirement, the "reasonable period" begins on the date when the child is placed in foster care and continues to the date when the proof is provided or when the department establishes that the parent or guardian is no longer making a good-faith effort to obtain the proof.

This rule is intended to implement Iowa Code sections 234.6(1) and 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.3(234) Voluntary placements.

202.3(1) All voluntary placement agreements initiated after July 1, 2003, for children under the age of 18 shall terminate after 90 days.

202.3(2) When the voluntary placement is of a child who is under the age of 18, a Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

202.3(3) Voluntary placement of a child aged 18 or older may be granted for six months at a time.

a. The department shall enter into the agreement only when the child:

(1) Meets the definition of "child" in Iowa Code section 234.1,

(2) Was in foster care or a state institution immediately before reaching the age of 18,

(3) Has continued in foster care or a state institution since reaching the age of 18,

(4) Has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case permanency plan, and

(5) Will be placed in foster family care or supervised apartment living in Iowa.

b. Payment shall be limited pursuant to 441—paragraph 156.20(1)*"b."*

c. When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the guardian and the local office where the guardian resides. Voluntary Foster Care Placement Agreements shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

d. When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the child and the local office where the child resides.

e. An exception to the requirement for continuous placement may be made for a youth who leaves foster care at age 18 and voluntarily returns to supervised apartment living foster care before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED).

202.3(4) All voluntary placements shall be approved by the service area manager or designee.

This rule is intended to implement Iowa Code sections 234.6(6)*"b"* and 234.35(1)*"c."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.4(234) Selection of facility.

202.4(1) Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

202.4(2) Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

202.4(3) The department shall first consider placing the child in a relative's home unless no relatives are available or willing to accept placement or such placement would be detrimental to the child's physical, emotional or mental well-being.

a. If a relative or a suitable person who has a kinship bond with the child will accept placement of the child:

(1) The person shall sign Form 595-1489, Non-Law Enforcement Record Check Request, and

(2) The department shall complete record checks as listed in 441—subrule 113.13(1) to evaluate if the person's home is appropriate for the child before making the placement.

b. Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

202.4(4) If the child cannot be placed with a relative or a suitable person who has a kinship bond with the child, foster family care shall be used for a child unless the child has problems which require specialized services that cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

202.4(5) A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

a. The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

b. The child's individual problems, medical needs, and plans for future care. The department shall not place a child with asthma or other respiratory health issues in a foster home where any member of the household smokes.

c. The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

d. The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

e. An environment that will cause minimum disruption of the child including few changes in placement for the child.

f. Rescinded IAB 4/11/07, effective 7/1/07.

202.4(6) A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current contract with the department pursuant to 441—Chapter 152.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.5(234) Preplacement.

202.5(1) Except for placements made in less than 24 hours, a child placed in a facility shall have a preplacement visit involving:

a. The child,

b. The foster parents or agency staff, if the child is placed in a public or private agency,

c. The department service worker, and

d. The child's parents, unless their presence would be disruptive to the child's placement.

202.5(2) Before placement, the worker shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns including safety-related information, educational plans, and permanency goal. Safety-related information shall be withheld only if:

a. Withholding the information is ordered by the court; or

b. The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.5(3) The child shall have a physical examination by a physician before the initial placement in foster care or within 14 calendar days of placement. The physician shall complete a preliminary screening for dental and mental health and refer the child to a dentist or mental health professional if appropriate. To address any immediate medical needs, the child shall be seen immediately at an emergency room, an urgent care center, or other community health resource.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.6(234) Placement.

202.6(1) At the time of placement, the department worker shall furnish to the foster care provider any available information regarding the child.

a. The information provided shall include:

(1) The child's full name and date of birth;

(2) The names, work addresses, and telephone numbers of the placement worker and the worker's supervisor, including a home telephone, cell phone, or on-call number;

(3) The names, addresses, and telephone numbers of the child's physician and dentist;

(4) The names, addresses, and telephone numbers of significant relatives of the child, including parents, grandparents, brothers and sisters, aunts and uncles, and any other significant persons (for an adopted child, the adoptive parents and adoptive relatives);

(5) The case permanency plan;

(6) The results of a physical examination, including immunization history;

(7) The child's medical needs including allergies, physical limitations, dental and medical recommendations, and special needs of HIV;

(8) Behavioral patterns including safety-related information;

(9) Educational arrangements including, but not limited to, the school the child attends, special education needs, and school contacts;

(10) The placement contract or agreement including the date of acceptance for care;

(11) Medical authorizations, service authorizations, and other releases as needed; and

(12) If the child is an Indian, the identification of the child's tribe and tribal social service agency including telephone number and contact person.

b. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

(1) The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

(2) Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

c. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.6(2) For each foster care placement in a foster family home supervised directly by department staff, Form 470-0716 or 470-0716(S), Foster Family Placement Contract, shall be completed by the foster family and the placement worker and supervisor. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

202.6(3) A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

202.6(4) The case permanency plan shall be reviewed at least every six months to ensure appropriateness of the child's placement. A copy of the subsequent case plan shall be submitted to the court every six months unless the court orders a different frequency for reports.

202.6(5) In conjunction with the case plan review, the case shall be presented every six months to a review committee which conforms to the requirements in subrule 202.2(5). The service area manager may also approve a review by a local foster care review board authorized in Iowa Code section 237.19 or the court as meeting this requirement as long as the review conforms to subrule 202.2(5), paragraphs *"b"* to *"h,"* and to subrule 202.6(5), paragraphs *"a"* to *"e."* The review committee shall:

a. Evaluate the continuing necessity for foster care placement.

b. Evaluate the continuing appropriateness of the foster care placement.

c. Evaluate the extent of compliance with the case plan.

d. Evaluate the extent of progress made toward lessening the causes for foster care placement.

e. Project a likely date by which the child will leave foster care.

This rule is intended to implement Iowa Code sections 234.6(6)*"b,"* and 237.19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.7(234) Out-of-area placements.

202.7(1) When the department makes a placement of a child in the foster care system out of the service area in which the child resides, this placement shall occur only when there is no appropriate placement within the service area, when the placement is necessary to facilitate reunification of the child with the parents, or when an out-of-area agency is closer to the community where the child resides than an in-area agency offering the same services.

202.7(2) The authority for approving out-of-area placements rests with both the placing and receiving service area managers.

202.7(3) Transfer of responsibility for supervision, planning, and visitation shall be approved by the placing and receiving service area managers and, when appropriate, by the court.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.8(234) Out-of-state placements.

202.8(1) The department shall make an out-of-state foster family care placement only with the approval of the service area manager or designee. Approval shall be granted only when the placement will not interfere with the goals of the child's case permanency plan and when one of the following conditions exists:

a. The foster family with whom the child is placed is moving out of state.

b. An out-of-state family having previous knowledge of the child desires to provide foster care to the child.

c. An out-of-state family is approved to adopt the child under subsidy and is eligible to receive maintenance payments until the adoption is final.

d. An out-of-state placement is necessary to facilitate reunification of the child with the parents.

202.8(2) Placements shall be made in an out-of-state group care facility only with the approval of the service area manager or designee.

202.8(3) All out-of-state placements shall be made pursuant to interstate compact procedures.

202.8(4) The reasons for selecting an out-of-state placement shall be documented in the child's case permanency plan.

202.8(5) Regional out-of-state placement committees. Rescinded IAB 7/6/94, effective 7/1/94.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.9(234) Supervised apartment living. A supervised apartment living arrangement shall provide a child with an environment in which the child can experience living in the community with supervision and prepare for self-sufficiency. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting and must be able to follow the provisions of the case plan and participate in activities and services to achieve self-sufficiency.

202.9(1) *Living arrangements.*

a. The two types of supervised apartment living arrangements are as follows:

(1) A cluster setting, which provides support in a structured setting. Up to six children reside in apartments or bedrooms in one building (such as an apartment building or residential housing), supervised by one agency. The supervising agency must have an adult staff member present and available on site in the living arrangement at any time when more than one child is present.

(2) A scattered-site setting, which is the less restrictive of the two types of living arrangements. Up to three children supervised by one agency may reside in individual housing arrangements, such as apartments or residential housing, located in one building. Children must be able to contact supervising agency staff 24 hours a day, seven days a week.

b. If an agency rents an apartment to the child, there shall be a signed lease between both parties that includes, but is not limited to:

(1) Amount to be paid for the rental unit.

(2) The term of the lease with both a beginning and an ending date.

(3) Rights and responsibilities of the tenant.

(4) Rights and responsibilities of the landlord.

(5) Conditions under which the lease can be terminated.

202.9(2) *Eligibility.* To be eligible for supervised apartment living placement, a child shall meet all of the following conditions:

a. The child must be at least 16½ years old for placement in a cluster setting.

b. The child must be at least 17 years old for placement in a scattered-site setting.

c. If the child is under the age of 18, the child must:

(1) Satisfactorily attend school, in accordance with the school's attendance policies, with the objective of obtaining a high school diploma; or

(2) Satisfactorily attend an instructional program, pursuant to the program's policies, necessary to obtain a general equivalency diploma (GED); or

(3) Attend school to obtain postsecondary education or training on a full-time basis (based upon the institution's definition of full-time) or attend on a part-time basis and be either working or participating in a work training program leading to employment; or

(4) Work at least an average of 80 hours per month if not enrolled in school; or

(5) Participate in a work training program leading to employment if not enrolled in school.

d. If the child is aged 18 or older, the child must:

(1) Meet the definition of "child" in Iowa Code section 234.1; and

(2) Have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. The service area manager or designee may waive the requirement for continuous placement for a child who leaves foster care at age 18 and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED, consistent with Iowa Code sections 234.35(1)*"f"* and 234.35(3)*"c"*; and

(3) Attend school on a full-time basis leading to a high school diploma or attend an instructional program leading to a GED.

e. The child must need foster care placement and services, based on an assessment completed according to rule 441—202.2(234) and subrule 202.6(5).

f. The child must participate in services and activities to achieve self-sufficiency.

g. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting, as determined by an assessment that reviews available information on the child to identify the needs, strengths, and resources of the child, especially as they pertain to the child's ability to function in the community. To determine if a supervised apartment living foster care placement is suitable for the child, the department worker must complete Form 470-4063, Preplacement Screening for Supervised Apartment Living Foster Care.

h. The child must have an approved living situation that meets the following minimum standards:

(1) Comply with applicable state and local zoning, fire, sanitary and safety regulations.

(2) Be located so as to provide reasonably convenient access to schools, places of employment, and services and supports required by the child.

(3) Be reasonably priced so as to fit within the child's budget.

i. If supervised apartment living foster care is deemed suitable for the child, the worker shall complete Form 470-3186, Request for Approval of Supervised Apartment Living Foster Care Placement, to request that the service area manager or designee approve the placement. This form is also to be used to request that the service area manager or designee waive the requirement for continuous placement for a child who leaves foster care on or after the child's eighteenth birthday and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED.

j. The placement must have the approval of the juvenile court if the child is under court jurisdiction.

202.9(3) *Services to be provided.* To ensure that the supervised apartment living arrangement is meeting the child's needs, required services shall be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. The following services are required:

a. Development of a case or service plan (by either the department worker or the service provider, if contracted out) in consultation with the child and the child's family (unless a reason for noninvolvement is documented in the case record) and significant others whenever appropriate that documents the following:

(1) Goals, intended to meet the specific needs of the child to achieve self-sufficiency, with projected dates of accomplishment.

(2) Objectives (action steps) to be taken by the child, the child's support system, and staff, with projected dates of accomplishment.

(3) Services to be provided and activities to be undertaken, the frequency of such services, who will provide the services, the child's progress with the goals and objectives, and the child's compliance with the service plan.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, any earned or unearned incomes and financially related assistance (e.g., food assistance). Staff will work with the child to ensure payment of bills and receipt of necessary items as outlined in the budget.

b. Life skills training involving interpersonal and daily living skills training to prepare the child to maintain a safe, healthy, and stable lifestyle and achieve self-sufficiency. Life skills training includes training of "hard" skills (e.g., money management, self-care and hygiene, physical and mental health care, skills related to educational and employment goals, housing and home management, time management, accessing community resources) and training of "soft" skills (e.g., decision making, problem solving, developing healthy relationships, self-advocacy). Life skills training should be individualized to the needs of the child toward achieving self-sufficiency. If a child needs a specific life skills training service or services (e.g., parenting skill development, counseling services to reduce stress and social, emotional, or behavioral problems that affect the child's stability or ability to achieve self-sufficiency) in addition to basic life skills training services and services are purchased,

the department worker will specify the necessary services under special provisions on Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL).

c. Through visits with the child and to the living situation, determination and documentation that:

(1) The living arrangement and mode of living are safe and suitable and provide an environment that allows for the child's social and emotional needs to be met; and

(2) There is no reasonable cause to believe that the child's living situation or mode of living presents any unacceptable risks to the child's health or safety; and

(3) The child has access to a telephone; and

(4) There is an operating smoke alarm on each level of occupancy; and

(5) The child is receiving any necessary medical care; and

(6) The child is receiving appropriate and sufficient services and supports to achieve the child's goals and facilitate objectives according to the child's service plan.

d. Supervision to assist the child in developing the needed structure to live in the supervised apartment living setting and in locating and using other needed services. If the child is under the age of 18, supervision shall include a minimum of weekly face-to-face contacts. For a child aged 18 or older, supervision shall include a minimum of biweekly (every other week) face-to-face contacts. Supervision may include guidance, oversight, and behavior monitoring.

e. Ongoing assessment activities to monitor the child's ability to achieve self-sufficiency.

f. If services are purchased, visits by the department to the child according to subrule 202.11(2).

g. If services are purchased, compliance by the provider with all reporting requirements in 441—paragraph 150.3(3)*"j,"* including requirements for the individual service plan, quarterly reports, and a termination summary.

h. A review of the case and case plan every six months, in accordance with subrules 202.6(4) and 202.6(5).

202.9(4) *Method of service provision.* Supervised apartment living services may be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. If services are purchased:

a. Department staff shall be responsible to determine the specific service components and the specific number of service units to be provided for required services. The department case permanency plan shall specify the goals and objectives (action steps) of the services that are being purchased. If services are purchased, the worker shall complete Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL), to place the child with the contractor and to authorize service codes (scattered-site or cluster setting; individual services or services provided with a group of children in supervised apartment living placement) and the specific number of units to be provided and billable.

b. Service billings for services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), of:

(1) Direct face-to-face contact between the service provider and the child.

(2) Activities undertaken to assist the child in developing the needed structure and supports to live in the supervised apartment living setting.

(3) Activities undertaken to assist the child in locating and using other needed services, supports, and community resources and to consult and collaborate on service directions on behalf of the child with schools, employers, landlords, volunteers, extended family members, peer support groups, training resources, or other community resources.

c. Service billings for group services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), for each child in the group.

d. Expenses of transporting the child, service management activities, and other administrative functions shall be allowable indirect costs subject to the restrictions set forth in rule 441—150.3(234) and are not billable units of service.

e. Contractors providing a cluster setting shall be paid $500 per month per child in the setting for agency staffing costs, in addition to billable units of services provided to the child, but are eligible for

this payment only when two or more children are in the setting. For a child who enters a cluster setting during the month, the prorated amount per day is $16.44. If a child exits the setting on or before the last day of the month, the $500 shall be prorated up to the date before the date of exit.

202.9(5) *Termination of services.*

a. Mandatory termination. Supervised apartment living services shall be terminated when the child:

(1) No longer meets eligibility criteria;

(2) No longer needs services or needs a more restrictive level of placement;

(3) Chooses to live in a nonapproved setting; or

(4) Refuses to follow the provisions of the case plan.

b. When services are purchased and the department plans to remove a child from the supervised apartment living placement, the department shall inform the provider in writing of the date of removal, the reason for the removal, the recourse available, if any, and that the contested case (appeal) proceeding does not apply to the removal.

c. The provider shall be informed ten days in advance of the removal, except when the court orders removal of the child from the placement or there is evidence of neglect or physical or sexual abuse.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 0417C**, IAB 10/31/12, effective 1/1/13]

441—202.10(234) Services to foster parents. Foster parents shall be provided necessary supportive services for the purpose of aiding them in the care and supervision of the child. These services shall include, but not be limited to:

202.10(1) Availability of social service staff on a 24-hour basis in case of emergency.

202.10(2) Conferences to develop in-depth planning regarding family visits, expectations of the department, future objectives and time frames, use of resources, and termination of placements.

202.10(3) Visitation by the service worker at least monthly regardless of the duration of the placements.

202.10(4) Making available all known pertinent information needed for the care of the child including HIV status, safety-related information, and special confidentiality requirements.

a. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information. The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

b. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. When continued breastfeeding of the child is determined to be in the best interest of the child, the service worker and the foster parents shall make reasonable efforts to support the continued breastfeeding of the child by the mother.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.11(234) Services to the child. The department service worker shall maintain a continuous relationship with the child.

202.11(1) The department service worker shall:

a. Help the child plan for the future,

b. Evaluate the child's needs and progress,

c. Supervise the living arrangement,

d. Arrange for social and other related services including, but not limited to, medical, psychiatric, psychological, and educational services from other resources as needed, and

e. Counsel the child in adjusting to the placement.

202.11(2) The assigned department service worker shall personally visit each child in out-of-home care at least once every calendar month, with the frequency of the vists based upon the needs of the child.

a. The visit shall take place in the child's place of residence the majority of the time.

b. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

202.11(3) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding for the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

202.11(4) When a child is in continuous foster care, a new physical examination shall not be required when the child transfers from one foster care placement to another unless there is some indication that an examination is necessary. The service worker shall obtain from the health practitioner or practitioners an annual medical review of treatment the child has received.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

202.11(5) Throughout the provision of care, the foster care provider shall actively ensure that the child stays connected to the child's kin, culture, and community as documented in the child's case permanency plan.

202.11(6) When the child has reached the age of majority under state law, the department shall provide a free copy of the child's health and education records to the child when the child leaves foster care.

202.11(7) Independent living program. The purpose of the independent living program is to provide supports and services that assist children currently or formerly in foster care in acquiring skills and abilities necessary for successful adult living. The independent living program offers a life skills assessment, transition plan development, and transition services.

a. *Eligibility.* To be eligible for the independent living program, a child must be or have been in foster care as defined by rule 441—202.1(234) or 45 Code of Federal Regulations 1355.20 as amended to October 1, 2008, and must meet at least one of the following eligibility requirements:

(1) Is currently in foster care and is 16 years of age or older.

(2) Is under the age of 21 and was adopted from foster care on or after October 7, 2008, and was at least 16 years of age at the time of adoption.

(3) Is under the age of 21 and was placed in a subsidized guardianship arrangement from foster care on or after October 7, 2008, and was at least 16 years of age at the time of placement.

(4) Was formerly in foster care and is eligible for and participating in Iowa's aftercare services program as described at 441—Chapter 187.

(5) Was formerly in foster care and is eligible for and participating in Iowa's education and training voucher (ETV) program as described at 42 U.S.C. 677(a)(6-7).

b. *Assessment.* A life skills assessment shall be administered to all children in foster care who are aged 16 or older. An assessment shall be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a."* The assessment is designed to evaluate the child's strengths and needs in areas including, but not limited to:

(1) Education,

(2) Physical and mental health,

(3) Employment,

(4) Housing and money management, and

(5) Supportive relationships.

c. *Transition plan development.* A transition plan shall be completed for all children in foster care who are aged 16 or older, as provided in Iowa Code section 232.2(4)*"f."* Transition plan development shall also be available upon request to any child who has been discharged from foster care but meets the

eligibility requirements in paragraph *"a,"* but the transition plan will not be part of a case permanency plan.

(1) The transition plan shall be personalized at the direction of the child and shall be developed and reviewed by the department in collaboration with a child-centered transition team, honoring the goals and concerns of the child.

(2) The transition plan shall address the strengths and needs identified in the assessment; detail the steps, services, supports and referrals needed to implement the plan to best assist the child in preparing for adulthood; and document the membership of the transition team and the meeting dates for the team.

(3) The transition plan shall be reviewed and updated at each case review after the plan's initial development; within 90 days before the child's eighteenth birthday; and within 90 days before the child is expected to leave foster care if the child remains in care after reaching the age of 18.

d. *Transition services.* Children shall be offered services, supports, and referrals within some or all of the five areas described below according to the child's strengths and needs as documented by the transition plan.

(1) Education skills increase the child's chances of completing high school or obtaining a GED and of entering a satisfying career. Services may include assistance in academic advising and guidance, secondary and postsecondary educational support, records transfer coordination, tutoring, financial aid planning, career exploration, mentoring, and career advising. Education financial assistance may be available to eligible children.

(2) Physical and mental health skills promote healthy physical, mental and emotional functioning. Health education services may include guidance on risk prevention, how to be healthy and fit, how to self-advocate for health care needs, how to select medical professionals, and how to make informed decisions regarding treatment, lifestyle considerations, spirituality, and recreation.

(3) Employment skills enable children to prepare for, seek, and maintain gainful career employment. Services may include employment programs or vocational training, employment search resources, career advising, résumé writing, interview skills, workplace etiquette, and on-the-job training.

(4) Housing and money management skills prepare a child to select, manage, and maintain safe and stable housing. Services may include lessons on the physical maintenance and cleaning of a house and guidance on managing personal finances, such as financial decisions, budgeting, bill paying, use of credit, and financing. Financial assistance for room and board may be available to children who meet the eligibility criteria of the preparation for adult living program pursuant to 441—Chapter 187.

(5) Supportive relationships skills promote the healthy development and maintenance of rewarding, lasting relationships. Services may include family support and healthy marriage education, mentoring opportunities, and guidance on how to recognize the needs of others, how to identify and understand personal motivations, how to ensure personal safety, and how to communicate effectively.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8718B**, IAB 5/5/10, effective 7/1/10; **ARC 0417C**, IAB 10/31/12, effective 1/1/13]

441—202.12(234) Services to parents.

202.12(1) Child welfare services shall be made available to the parents throughout the period of placement for the purpose of reuniting the family in an agreed-upon time frame. Family safety, risk, and permanency services may be provided to:

a. Promote identification and enhancement of family strengths and protective capacities;

b. Address the factors that resulted in the child's being removed from the family home; and

c. Strengthen family connections to community resources and informal supports.

202.12(2) Placement notification.

a. The parents shall be notified of the location and nature of the child's placement, unless the conditions of this subrule are met.

(1) The department evaluates the situation and determines that notifying the child's parents of the location of the placement would be detrimental to the child's safety and well-being and to the stability of the child's placement due to:

1. Evidence of a direct or indirect threat to harm the foster child or the foster family; or

2. Credible third-party information of a threat of harm to the foster child or the foster family.

(2) The department includes a statement in the child's case permanency plan explaining the decision not to disclose the location of the child to the parents.

b. The decision not to disclose the location of a child's placement shall be reviewed at least every six months when the child's case permanency plan is revised.

202.12(3) The case plan and treatment plan shall specify the services to be provided and the time frame for reuniting the family. These plans shall be developed in cooperation with the parents.

202.12(4) Personal contact shall be made regularly with the parents and the progress towards goal attainment reviewed and documented in the case record. The frequency of the personal contact shall be at least monthly and shall be specified in the child's case permanency plan.

202.12(5) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding of the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 9961B**, IAB 1/11/12, effective 12/15/11]

441—202.13(234) Removal of the child.

202.13(1) When the department plans to remove a child from a facility, the facility shall be informed in writing of the date of the removal, the reason for the removal, the recourse available to the facility, if any, and that the chapter 17A contested case proceeding is not applicable to the removal. The department shall inform the facility ten days in advance of the removal, except that the facility may be informed less than ten days prior to the removal in the following instances:

a. When the parent or guardian removes the child from voluntary placement.

b. When the court orders removal of a child from placement.

c. When there is evidence of neglect or physical or sexual abuse.

202.13(2) The department may remove a child from a facility when any of the following conditions exist:

a. There is evidence of abuse, neglect, or exploitation of the child.

b. The child needs a specialized service that the facility does not offer.

c. The child is unable to benefit from the placement as evidenced by lack of progress of the child.

d. There is evidence the facility is unable to provide the care needed by the child and fulfill its responsibilities under the case plan.

e. There is lack of cooperation of the facility with the department.

202.13(3) If a foster family objects in writing within seven days from the date that the department furnishes notice of plans to remove the child, the service area manager or designee shall grant a conference to the foster family to determine whether the removal is in the child's best interest.

a. This conference shall not be construed to be a contested case under the Iowa administrative procedure Act, Iowa Code chapter 17A.

b. The conference shall be provided before the child is removed except in instances listed in 202.13(1)*"a"* to *"c."* The service area manager or designee shall review the propriety of the removal and explain the decision to the foster family.

c. The service area manager or designee, on finding that the removal is not in the child's best interests, may overrule the removal decision unless a court order or parental decision prevents the department from doing so.

202.13(4) When the facility requests a child be removed from its care, it shall give a minimum of ten days' notice to the department so planning may be made on behalf of the child.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.14(234) Termination. The foster care services shall be terminated when the child is no longer an eligible child, or when the attainment of goals in the case plan has been achieved, or when the goals for whatever reasons cannot be achieved, or when it is evident that the family or individual is unable to benefit from the service or unwilling to accept further services.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.15(234) Case permanency plan.

202.15(1) The department worker shall ensure that a case permanency plan is developed for each child who is placed in foster care if the department has agreed to provide foster care through a voluntary placement agreement, if a court has transferred custody or guardianship to the department for the purpose of foster care, or if a court has placed the child in foster care and ordered the department to supervise the placement.

202.15(2) The department worker shall develop the case permanency plan with the child's parents, unless the child's parents are unwilling to participate in the plan's development, and with the child, unless the child is unable or unwilling to participate.

202.15(3) The department worker shall be responsible for ensuring the development of the case permanency plan within the time frames specified in rule 441—130.7(234). In all cases, the case permanency plan shall be completed within 60 days of the date the child entered foster care.

202.15(4) Copies of the initial and subsequent case permanency plans shall be provided to the child, the child's parents, and the foster care provider. Copies shall also be provided to the following, if involved in services to the child: the juvenile court officer, the judge, the child's attorney, the child's guardian ad litem, the child's guardian, the child's custodian, the child's court-appointed special advocate, the parents' attorneys, the county attorney, the state foster care review board, and any other interested parties identified in the plan.

202.15(5) The initial and subsequent case permanency plans shall be completed on the forms specified in rule 441—130.7(234).

202.15(6) Rescinded IAB 4/28/04, effective 6/2/04.

441—202.16(135H) Department approval of need for a psychiatric medical institution for children.

202.16(1) Applicants for departmental approval of need shall submit the following to the division of child and family services:

a. A description of the population to be served, including age, sex, and types of disorders, and an estimate of the number of these youth in need of psychiatric care in the area of the state in which the applicant is located.

b. A statement of the number of beds requested and a description of the treatment program to be provided, the outcomes to be achieved and the techniques for measuring outcomes.

c. A proposed date of operation as a psychiatric medical institution for children.

d. A description of the applicant's experience with providing similar services to youth, especially the target population.

e. A description of the applicant's plan, including the timeline for achieving accreditation to provide psychiatric services from a federally recognized accrediting organization under the organization's standards for residential settings and licensure as a psychiatric medical institution for children, or a copy of the organization's report if already accredited.

f. References from the service area manager for the department service area in which the proposed psychiatric medical institution for children would be located, the chief juvenile court officer of the judicial district in which the proposed psychiatric medical institution for children would be located and the applicant's licensor from the department of inspections and appeals or department of public health.

202.16(2) The department shall evaluate proposals and issue a decision based on the following criteria:

a. The number of psychiatric medical institutions for children beds for the proposed population which are needed in the area of the state in which the facility would be located, based on the department's most recent needs assessment.

b. The steps the facility has taken towards achieving accreditation from a federally recognized accrediting organization and licensure as a psychiatric medical institution for children.

c. The applicant's ability to provide services and support consistent with the requirements under Iowa Code chapter 232 including, but not limited to, evidence that:

(1) Children will be served in a setting which is in close proximity to their parents' home.

(2) Each child will receive services consistent with the child's best interests and special psychiatric needs as identified in the child's case permanency plan.

(3) Children and their families will receive services to facilitate the children's return home or other permanent placement.

d. The applicant's ability to provide children with a non-hospital-type living environment if the applicant is not freestanding from a hospital or health care facility.

e. The limits on the number of beds found in Iowa Code section 135H.6, subsection 5.

202.16(3) If a facility has not been licensed as a psychiatric medical institution for children within one year after the date of the department's approval of need, the department's approval shall expire unless the department has approved an extension. An extension may be approved up to a maximum of six months if the agency has documented extenuating circumstances which prevented completion of the licensing process.

This rule is intended to implement Iowa Code section 135H.6.

441—202.17(232) Area group care targets.

202.17(1) *Area target.* A group care budget target shall be established for each departmental service area, which shall be based on the annual statewide group care appropriation established by the general assembly.

a. The department and the judicial branch shall jointly develop a formula for allocating the group care appropriation among the departmental service areas. The formula shall be based on:

(1) Proportional child population.

(2) Proportional group foster care usage in the previous five completed fiscal years.

(3) Other indicators of need.

b. Any portion of the group care appropriation allocated for 50 highly structured juvenile program beds and not used may be used for group care.

c. Upon written agreement of the affected service area managers and chief juvenile court officers, service areas may transfer part of their group care budget from one service area to another. A service area may exceed its budget target figure up to 5 percent during the fiscal year, providing that the overall funding allocation by the department for all child welfare services in the service area is not exceeded.

d. Notwithstanding the statewide appropriation established in this subrule, a budget established in a service area's group care plan pursuant to Iowa Code section 232.143 may be exceeded, a group care placement may be ordered, and state payment may be made if the review organization finds that the placement is necessary to meet the child's service needs and if the service area has additional funds transferred from another service area or if the service area is within 5 percent of its group care budget target figure pursuant to 441—paragraph 202.17(1)*"c."*

The department and juvenile court services shall work together to ensure that a service area's group care expenditures shall not exceed the funds allocated to the service area for group care in the fiscal year.

e. If at any time after September 30, 1998, annualization of a service area's current expenditures indicates a service area is at risk of exceeding its group foster care expenditure target under Iowa Code section 232.143 by more than 5 percent, the department and juvenile court services shall examine all group foster care placements in that service area in order to identify those which might be appropriate for termination. In addition, any aftercare services believed to be needed for the children whose placements may be terminated shall be identified.

The department and juvenile court services shall initiate action to set dispositional review hearings for the placements identified. In the dispositional review hearing, the juvenile court shall determine whether needed aftercare services are available and whether termination of the placement is in the best interest of the child and the community.

202.17(2) *Plan for achieving target.* For each of the departmental service areas, representatives appointed by the department and juvenile court services shall establish a plan for containing the expenditure for children placed in group care within the budget target allocated to that service area. The plan shall include monthly targets and strategies for developing alternatives to group care placements.

The plans shall also ensure potential group care referrals are reviewed by the review organization prior to submission of a recommendation for group care placement to the court.

Each area plan shall be established in advance of the fiscal year to which the plan applies. To the extent possible, the department and the juvenile court shall coordinate the planning required under this subrule with planning for services paid under Iowa Code section 232.141, subsection 4. The department's service area manager shall communicate regularly, as specified in the area plan, with the juvenile courts within the service area concerning the current status of the plan's implementation.

This rule is intended to implement Iowa Code section 232.143.

441—202.18(235) Local transition committees. Local transition committees shall be established in each of the department service areas. The service area manager or designee shall determine the number of local transition committees needed within the service area, set operating policies and procedures, and appoint committee membership.

202.18(1) *Purpose.* The purpose of local transition committees, as established by Iowa Code Supplement section 235.7, is to ensure that the transition needs of youth in foster care who are 16 years of age or older have been addressed in order to assist the youth in preparing for the transition from foster care to adulthood.

202.18(2) *Membership.* Each committee shall have a designated number of members.

a. The standing committee membership may include, but is not limited to:

(1) Department staff involved with child welfare, adult services, or transition planning.

(2) Juvenile court services staff.

(3) Adult service system staff.

(4) Education staff.

(5) Service care provider representation.

(6) Others knowledgeable about community resources.

b. Additionally, nonstanding membership may include those knowledgeable about the youth, including the child's court-appointed special advocate, guardian ad litem, and service or care providers.

c. In areas where teams or boards already in existence are involved in review and planning for youth needs, such as the foster care review board or child welfare funding decategorization boards, such teams or boards may serve as local transition committees.

202.18(3) *Duties.* Local transition committees shall address the transition needs of youth in foster care who are 16 years of age or older and who have a case permanency plan as defined in Iowa Code Supplement section 232.2. Each committee shall have operating policies and procedures to carry out the duties below.

a. Each committee shall establish a process for review and approval of written transition plans for youth for whom the committee has placement responsibility that meets a continuum of case needs and coordinates with local transition planning protocol. The process may include a paper review or an in-person review, or both, according to case need.

b. The committee may be involved when the youth is at least 16 years of age, but shall be involved in reviewing and approving a youth's transition plan before the youth reaches age 17½. When a youth enters foster care at age 17½ or older, the committee shall be involved in reviewing and approving the youth's transition plan within 30 days of completion.

c. In reviewing a youth's transition plan, the committee shall identify and act to address gaps existing in services or supports available that would assist the youth in the transition from foster care to adulthood.

d. For those youth expected to need services as adults, the committee shall ensure that the transition plan was developed with the participation of any person reasonably expected to be a service provider when the youth becomes an adult or to become responsible for the costs of services at that time.

e. The committee shall ensure that transition planning and review is coordinated with overall case planning and review. Committee review and approval shall be indicated in the youth's case permanency plan.

f. With respect to meetings involving a specific youth receiving foster care and the youth's family, the local transition committees are not subject to Iowa Code chapter 21.

g. The information and records of or provided to a local transition committee regarding a youth receiving foster care and the youth's family are not public records pursuant to Iowa Code chapter 22 when the records relate to the foster care placement and transition needs of the youth.

h. Members of the committees are subject to the standards of confidentiality set forth in Iowa Code sections 600.16, 217.30 and 235A.15.

202.18(4) *Report.* The service area manager or designee shall submit a report on transition planning committees to the department's division of child and family services. The report shall be submitted annually by October 1 for the immediately preceding fiscal year. The report shall include, but not be limited to, the following:

a. The geographical area covered for each committee within the service area.

b. Standing committee membership for each committee.

c. The number of cases reviewed by each committee.

d. Identification of barriers to successful transition and gaps in community services or supports.

e. Suggestions for ways to transition youth from foster care to adulthood more effectively.

This rule is intended to implement Iowa Code Supplement section 235.7.

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CHAPTER 203
IOWA ADOPTION EXCHANGE

PREAMBLE

The purpose of the Iowa adoption exchange as mandated by Iowa Code section 232.119, is to facilitate the placement of Iowa children who are legally available for adoption.

This chapter requires that children with special needs under state guardianship be registered on the Iowa adoption exchange within 60 days after termination of parental rights unless a deferral is granted according to Iowa Code section 232.119 and that all children under state guardianship for whom an adoptive home is not available within 90 days after termination be registered, not just children with special needs. Child-placing agencies may also register children under their guardianship whose parental rights have been terminated.

Department workers, child-placing agencies and certified adoption investigators shall register approved adoptive families, if the families wish to adopt a child with special needs or a sibling group.

441—203.1(232) Definitions.

"Certified adoption investigator" means a person as defined in Iowa Code chapter 600 and certified by the department under 441—Chapter 107.

"Child-placing agency" means an agency as defined in Iowa Code chapter 238 and licensed under 441—Chapter 108.

"Children with special needs" means children as defined in 441—subrule 201.3(1).

"Department" means the Iowa department of human services.

"Exchange" means the Iowa adoption exchange system.

"Iowa adoption exchange system" is a computerized system established to facilitate the adoptive placement of children by matching children legally available for adoption and approved families desiring to adopt a child with special needs or a sibling group and referring the families to the child's adoption worker.

"Prospective adoptive family" means a family residing in Iowa approved to provide an adoptive home for a child.

441—203.2(232) Children to be registered on the exchange system. All children with special needs under state guardianship shall be registered on the Iowa adoption exchange system within 60 days of receipt of the termination of parental rights court order, unless a deferral is granted by the adoption program manager. In addition to the children with special needs being placed on the exchange system, those children under state guardianship for whom an adoptive home is not available within 90 days after termination shall be placed on the exchange system by department staff. Department workers shall forward the child's photograph to the Division of Adult, Children and Family Services, Adoption Program, for photolisting in the Iowa's Waiting Children Book at the time that the child is registered on the Iowa adoption exchange system.

Licensed child-placing agencies may register a child whose parental rights have been terminated and who is under their guardianship using one of the following methods:

a. The agency shall submit Form 470-0751, Exchange Referral of Child/Sibling Group to the department for entry of the child's name and data if the agency is registering less than four children a calendar year.

b. The agency shall access the Iowa adoption exchange system and directly enter the child's name and data when the agency registers four or more children in a calendar year.

441—203.3(232) Families to be registered on the exchange system. Approved families wishing to adopt a child with special needs or a sibling group shall be registered on the exchange system by department staff.

Licensed child-placing agencies and certified adoption investigators shall register an approved family wishing to adopt a child with special needs or a sibling group on the exchange using one of the following methods:

a. Licensed child-placing agencies shall:

(1) Submit Form 470-0752, Exchange Referral of Family, to the department for entry of the family's name and data if the agency is registering less than four families a calendar year.

(2) Access the Iowa adoption exchange system and directly enter the family's name and data when the agency registers four or more families in a calendar year.

b. Certified adoption investigators shall submit Form 470-0752, Exchange Referral of Family, to the department for entry of the family's name and data.

Only families wishing to adopt a child with special needs or a child for whom no adoptive placement can be found within 90 days after termination will be placed on the exchange.

441—203.4(232) Matching process. Using the computerized Iowa adoption exchange system, department workers and licensed child-placing agencies shall search for approved families to meet the needs of the available children. The child's and family's workers shall be contacted for additional information needed to make an informed decision concerning possible adoptive placements.

These rules are intended to implement Iowa Code section 232.119.

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CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

PREAMBLE

This chapter implemented a five-year demonstration waiver project for a subsidized guardianship program to provide financial assistance to guardians of eligible children who are not able to be adopted and who are not able to return home. Notification has been given to the United States Department of Health and Human Services that the demonstration project will end effective September 1, 2010. A subsidized guardianship agreement authorized under this chapter will remain in effect until the agreement is terminated under the terms of this chapter.
[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.1(234) Definitions.

"Child" means a person who has not attained the age of 18.

"Department" means the Iowa department of human services.

"Guardianship subsidy" means a monthly payment to assist in covering the cost of room, board, clothing, and spending money for the child.

"Nonrecurring expenses" means reasonable and necessary guardianship fees, court costs, attorney fees, and other expenses that are directly related to finalizing the legal guardianship of a child. These expenses shall be limited to attorney fees, court filing fees and other court costs.

"Sibling group" means at least two children who are whole or half-siblings. A sibling group may include adopted children who have a common parent. Stepsiblings are not included as part of the sibling group.

441—204.2(234) Eligibility.

204.2(1) *General conditions of eligibility.* The guardian named in a permanency order under Iowa Code section 232.104(2)*"d"*(1) or Iowa Code chapter 633 for a child who was previously in the custody of the department is eligible for subsidy when all of the following conditions exist:

a. The child has a documented permanency goal of:

(1) Long-term foster care;

(2) Guardianship; or

(3) Another planned permanent living arrangement.

b. The child has been in a licensed foster care placement and has lived in foster care for at least 6 of the last 12 months.

c. The child is either:

(1) 14 years of age or older and consents to the guardianship; or

(2) 12 years of age or older and guardianship has been determined to be in the child's best interest; or

(3) Under 12 years of age and part of a sibling group with a child aged 12 or older.

d. The child has lived in continuous placement with the prospective guardian for the six months before initiation of the guardianship subsidy.

e. The guardian is a person who has a significant relationship with the child and demonstrates a willingness to make a long-term commitment to the child's care.

(1) The guardian may be a relative or nonrelative,

(2) Placement with that guardian must be in the best interest of the child. The best-interest determination must be documented in the case file.

f. The child has been randomly selected to participate in the waiver demonstration project.

204.2(2) *Residency.* The subsidized guardianship applicant or recipient need not reside in Iowa.

204.2(3) *Unearned income.* The family or the guardian shall provide to the department worker documentation from the source of the child's unearned income.

204.2(4) *Other services.* Rescinded IAB 10/11/06, effective 11/1/06.

441—204.3(234) Application. Applications for the subsidized guardianship program shall not be accepted after August 31, 2010.
[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.4(234) Negotiation of amount of subsidy.

204.4(1) *Subsidy agreement.* The amount of subsidy shall be negotiated between the department and the guardian, and shall be based upon the needs of the child, and the circumstances of the family. Each time negotiations are completed, the Guardianship Subsidy Agreement, Form 470-3631, shall be completed and signed by the guardian and the department worker.

204.4(2) *Amount of subsidy.* The department shall enter into the agreement based upon available funds. Each time negotiations are completed, the department worker and guardian shall complete Form 470-3631, Guardianship Subsidy Agreement.

a. The guardianship subsidy shall be based on a flat daily foster care rate adjusted according to the needs of the child and the circumstances of the family.

(1) The rate for the guardianship subsidy shall not exceed the state's current daily basic foster care rate plus any daily level 1 or 2 special needs allowance or sibling allowance for which the child is eligible, as found at 441—subrule 156.6(1) and 441—paragraphs 156.6(4)*"b"* and *"f."*

(2) Rescinded IAB 1/3/07, effective 1/1/07.

b. If the payment is less than the maximum amount allowed, the guardian may request an increase if the child's or family's needs and circumstances require additional resources.

204.4(3) *Placement outside of home.* If a child needs to be placed out of the guardian's home and the plan is for the child to return to the guardian within six months, a partial subsidy amount may be negotiated.

204.4(4) *Nonrecurring expenses.* The nonrecurring expenses necessary to finalize a guardianship shall be limited to the amount found in 441—subparagraph 201.6(1)*"a"*(7).

441—204.5(234) Parental liability. These subsidy payments are considered foster care payments for purposes of child support recovery and as such create a support debt for the parents.

441—204.6(234) Termination of subsidy. A guardianship subsidy agreement negotiated based on an application signed on or before August 31, 2010, shall remain in effect until the subsidy is terminated based on one of the grounds listed in this rule. The subsidy shall terminate when any of the following occur, and a notice shall be sent which states the reason for the termination:

1. The child reaches the age of 18, unless the department determines that the subsidy may continue until the child reaches the age of 19 to facilitate the child's completion of high school or a high school equivalency diploma.
2. The child marries or enlists in the military.
3. The child no longer lives with the guardian, except for placement outside the home as limited by subrule 204.4(3).
4. The relationship ends due to the death of the child or the death of the guardian of the child (one in a single-parent family or both in a two-parent family).
5. The terms of Form 470-3631, Guardianship Subsidy Agreement, are concluded.
6. The guardian requests that the guardianship payment cease.
7. Due to incapacity, the guardian can no longer discharge the responsibilities necessary to protect and care for the child, and the guardianship has been or will be vacated.
8. The guardian fails to abide by the terms of Form 470-3631, Guardianship Subsidy Agreement.
9. The guardianship case is terminated by court order.
10. The department funds for subsidized guardianship are no longer available.

[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.7(234) Reinstatement of subsidy. Reinstatement of the subsidy shall be made when the subsidy was terminated because of the guardian's request, and the guardian has requested reinstatement.

441—204.8(234) Appeals. The guardian may appeal adverse determination pursuant to 441—Chapter 7.

441—204.9(234) Medical assistance. Children eligible for subsidy are entitled to medical assistance as defined in 441—Chapter 75. When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the guardian.

The funding source for medical assistance is based on the following criteria:

1. Children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

2. Children from Iowa residing in another state shall receive medical assistance from the state of residence if eligible. Iowa shall provide medical assistance for children not eligible in their state of residence. Medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

3. Children from another state residing in Iowa shall continue to be covered by the other state's medical assistance unless the state has adopted the adoption assistance interstate compact and a contract between Iowa and the other state exists.

These rules are intended to implement Iowa Code section 234.6 and 2006 Iowa Acts, House File 2734, section 17, subsection 10.

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CHAPTER 205
Reserved