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In addition to the changes adopted by agencies, the replacement pages may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(4); an effective date delay imposed by the ARRC pursuant to section 17A.4(5) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(6); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index and for the preliminary sections of the IAC: General Information about the IAC, Chapter 17A of the Code of Iowa, Style and Format of Rules, Table of Rules Implementing Statutes, and Uniform Rules on Agency Procedure.

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IOWA ADMINISTRATIVE CODE

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CHAPTER 1
BUSINESS CONDUCT

[Prior to 6/15/88, see Real Estate Commission[700] Ch 1]

193E—1.1(543B) Definitions.

"Advance fees" shall mean any fees charged for services to be paid in advance of the rendering of such services including, without limitation, any fees charged for listing, advertising, or offering for sale or lease any real property, but excluding any fees paid solely for advertisement in a newspaper of general circulation.

"Affiliated licensee" means a broker associate or salesperson, as defined in Iowa Code section 543B.5, who is under the supervision of a broker.

"Brokerage agreement" means a contract between a broker and a client which establishes the relationship between the parties as to the brokerage services to be performed.

"Buyer" includes a purchaser, tenant, vendee, lessee, party to an exchange, or grantee of an option. Selected rules in this chapter will at times refer separately to "buyers" and "tenants" to clarify licensee's duties and obligations.

"Client" means a party to a transaction who has an agency agreement with a broker for brokerage services.

"Common source information companies" means any individual, corporation, limited liability company, business trust, estate, trust, partnership, association, or any other legal entity (except any government or governmental subdivision or agency, or any officer or employee thereof acting in such individual's official capacity) that is a source, compiler, or supplier of information regarding real estate for sale or lease and other data and includes, but is not limited to, multiple listing services.

"Confidential information" means information made confidential by statute, regulation, or express instructions from the client. Confidential information:

1. Shall include, but not be limited to, the following:

- Information concerning the client that, if disclosed to the other party, could place the client at a disadvantage when bargaining;
- That the seller or landlord is willing to accept less than the asking price or lease price for the property;
- That the buyer or tenant is willing to pay more than the asking price or lease price for the property;
- What the motivating factors are for the party selling or leasing the property;
- What the motivating factors are for the party buying or leasing the property;
- That the seller or landlord will agree to sale, lease, or financing terms other than those offered;
- That the buyer or tenant will agree to sale, lease, or financing terms other than those offered;
- The seller's or landlord's real estate needs;
- The buyer's or tenant's real estate needs;
- The seller's or landlord's financial information, except the seller's ability to sell and the landlord's ability to lease are considered a material fact;
- The buyer's or tenant's financial qualifications, except the buyer's ability to buy and the tenant's ability to lease are considered a material fact.

2. Does not include "material adverse facts" as defined in Iowa Code Supplement section 543B.5.

3. Shall not be disclosed unless:

• The client to whom the information pertains provides informed written consent to disclose the information;

• The disclosure is required by statute or regulation, or failure to disclose the information would constitute fraudulent representation;

• The information is made public or becomes public by the words or conduct of the client to whom the information pertains or from a source other than the licensee; or

• The disclosure is necessary to defend the licensee against an accusation of wrongful conduct in an actual or threatened judicial proceeding, an administrative proceeding before the commission, or in a proceeding before a professional committee.

"Consumer" means a person seeking or receiving real estate brokerage services.

"Contract between the buyer and seller" includes an offer to purchase, a sales contract, an option, a lease-purchase option, an offer to lease, or a lease.

"Customer" means a consumer of real estate services in connection with a real estate transaction who is not being represented by the licensee, but for whom the licensee may perform ministerial acts. A customer may be a client of another broker, may not have yet decided whether or not to be represented by any broker, or may have chosen not to be represented by any broker.

"Dual agent" means a licensee who, with the written informed consent of all the parties to a contemplated real estate transaction, has entered into a brokerage agreement with and therefore represents both the seller and buyer or both the landlord and tenant in the same in-house transaction.

"Firm" means a licensed partnership, association, or corporation.

"Licensee" means a designated broker as defined in Iowa Code Supplement section 543B.5, a broker associate as defined in Iowa Code section 543B.5(1), and a salesperson as defined in 543B.5(3).

"Listing broker" means the real estate broker who obtains a listing of real estate or of an interest in a residential cooperative housing corporation.

"Ministerial acts" means those acts that a licensee may perform for a consumer that are informative in nature and do not rise to the level of specific assistance on behalf of a consumer. For purposes of this rule, ministerial acts include, but are not limited to, the following:

1. Responding to telephone inquiries by consumers as to the availability and pricing of brokerage services;
2. Responding to telephone inquiries from a consumer concerning the price or location of property;
3. Attending an open house and responding to questions about the property from a consumer;
4. Setting an appointment to view property;
5. Responding to questions of consumers walking into a licensee's office concerning brokerage services offered or particular properties;
6. Accompanying an appraiser, inspector, contractor, or similar third party on a visit to a property;
7. Describing a property or the property's condition in response to a consumer's inquiry;
8. Completing business or factual information for a consumer on an offer or contract to purchase on behalf of a client;
9. Showing a client through a property being sold by an owner on the owner's own behalf; or
10. Referring a person to another broker or service provider.

"Seller" includes an owner, landlord, vendor, lessor, party to an exchange, or grantor of an option. Selected rules in this chapter will at times refer separately to "sellers" and "landlords" to clarify licensee's duties and obligations.

193E—1.40(543B) Disclosure of licensee interest, acting as a principal, and status as a licensee required. A licensee shall not act in a transaction on the licensee's own behalf, on behalf of the licensee's immediate family, including but not limited to a spouse, parent, child, grandparent, grandchild, brother, or sister, or on behalf of the brokerage, or on behalf of an organization or business entity in which the licensee has an interest, including an affiliated business arrangement as defined in subrule 1.50(1), unless the licensee provides written disclosure of that interest to all parties to the transaction. Disclosure required under this rule must be made at the time of or prior to the licensee's providing specific assistance to the party or parties to the transaction. Copies of the disclosure may be provided in person or by mail, as soon as reasonably practical. If no specific assistance is provided, disclosure shall be provided prior to the parties' forming a legally binding contract, either prior to an offer being made by the buyer or tenant or prior to an acceptance by the seller or landlord, whichever comes first.

1.40(1) *Licensee acting as a principal.* A licensee shall not acquire any interest in any property directly or indirectly nor shall the licensee sell any interest in which the licensee directly or indirectly has an interest without first making written disclosure of the licensee's true position clear to the other party. Satisfactory proof of this fact must be produced by the licensee upon request of the commission. Whenever a licensee is in doubt as to whether an interest, relationship, association, or affiliation requires disclosure under this rule, the safest course of action is to make the written disclosure.

1.40(2) *Status as a licensee.* Before buying, selling, or leasing real estate as described above, the licensee shall disclose in writing any ownership, or other interest, which the licensee has or will have and the licensee's status to all parties to the transaction. An inactive status license shall not exempt a licensee from providing the required disclosure.

1.40(3) *Dual capacity.* The licensee shall not act in a dual capacity of agent and undisclosed principal in any transaction.

193E—1.41(543B) Rebates and inducements.

1.41(1) A licensee shall not pay a commission, any part of the commission, or valuable consideration to an unlicensed third party for performing brokerage functions or engaging in any activity that requires a real estate license. Referral fees or finder's fees paid to unlicensed third parties for performing brokerage activities, or engaging in any activity that requires a real estate license, are prohibited.

1.41(2) In a listing contract, the broker is principal party to the contract. The broker may, with proper disclosure, pay a portion of the commission earned to an unlicensed seller or landlord that is a principal party to the listing contract. This will be deemed a reduction in the amount of the earned commission.

1.41(3) Rescinded IAB 6/28/00, effective 6/9/00.

1.41(4) A licensee may present a gratuitous gift, such as flowers or a door knocker, to the buyer or tenant subsequent to closing and not promised or offered as an inducement to buy or lease. The permission and disclosure requirements of 193E—1.42(543B) do not apply as long as any client relationship has terminated.

1.41(5) A licensee may present free gifts, such as prizes, money, or other valuable consideration, to a potential party to a transaction or lease, prior to signing a contract to purchase or lease and not promised or offered as an inducement to buy or lease. It is the licensee's responsibility to ensure that the promotion is in compliance with other Iowa laws, such as gaming regulations. The permission and disclosure requirements of 193E—1.42(543B) do not apply as long as no client relationship has been established with the buyer or lessee.

1.41(6) The offering by a licensee of a free gift, prize, money, or other valuable consideration as an inducement shall be free from deception and shall not serve to distort the true value of the real estate service being promoted.

1.41(7) Rescinded IAB 6/28/00, effective 6/9/00.

1.41(8) A licensee may make donations to a charity, or other not-for-profit organization, for each listing or closing, or both, that the licensee has during a specific time period. The receiving entity may be selected by the licensee or by a party to the transaction. The contribution may be in the name of the licensee or in the name of a party to the transaction. Contributions are permissible only if the following conditions are met:

a. There are no restrictions placed on the payment;

b. The donation is for a specific amount;

c. The receiving entity does not act or participate in any manner that would require a license;

d. The licensee exercises reasonable care to ensure that the organization or fund is a bona fide nonprofit;

e. The licensee exercises reasonable care to ensure that the promotional materials clearly explain the terms under which the donations will be made; and

f. All required disclosures are made.

193E—1.42(543B) Brokerage agreements. All brokerage agreements shall be written and cannot be assigned, sold, or otherwise transferred to another broker without the express written consent of all parties to the original agreement, unless the terms of the agreement state otherwise. Upon termination of association or employment with the principal broker, the affiliated broker associate or salesperson shall not take or use any written brokerage agreements secured during the association or employment. Said brokerage agreements remain the property of the principal broker and may be canceled only by the broker and the client.

1.42(1) Every written brokerage agreement shall include, at a minimum, the requirements set forth in Iowa Code Supplement section 543B.57 and the following provisions:

a. A statement disclosing the brokerage policy on cooperating with and compensating other brokerages whether the brokerage is acting as subagent or the other parties' agent in the sale, lease, rental, or purchase of real estate, including whether the brokerage intends to share the compensation with other brokerages. Such disclosure shall serve to inform the client of any policy that would limit the participation of any other brokerage;

b. All listing contracts and all brokerage agency contracts shall comply with Iowa real estate law and commission rules including, but not limited to, 193E—1.23(543B) Listings, 1.30(543B) Property management, and 1.20(543B) Terms and conditions.

1.42(2) No licensee shall make or enter into a brokerage agreement that specifies a net sale, lease, rental, or exchange price to be received by an owner and the excess to be received by the licensee as a commission.

193E—1.52(543B) Enforcement date. Rules 1.41(543B) to 1.51(543B) shall not be enforced until July 1, 1996. When the commission adopted these rules, which became effective January 24, 1996, it intended to delay enforcement until July 1, 1996, as stated in rule 1.41(543B). This rule is intended to clarify the enforcement date to avoid any possible confusion by licensees or the public more generally. The commission wants to provide licensees with the opportunity to obtain education and to become familiar with the rules prior to enforcement.

These rules are intended to implement Iowa Code chapters 558A and 543B and Iowa Code Supplement sections 543B.57 to 543B.63.

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d. The board will meet at least once per calendar quarter. The meetings will be held at the seat of government unless notification is given otherwise. Other meetings shall be held at the call of the chairperson or of any three members when necessary for the board to discharge its duties.

(1) The communications media shall be notified at least two weeks in advance of such meetings.

(2) 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.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

37.4(2) *Meetings.* All meetings will be open to the public unless specifically allowed to be closed under Iowa Code chapter 21.

a. Persons wishing to make a presentation shall make such request to the director, division of adult corrections, department of social services, or to any member of the board at least one week in advance of the scheduled meeting.

b. Persons making a presentation are requested to submit one written copy of their remarks for the record.

c. Persons who have not made previous arrangements to speak at a meeting may be given the floor at the discretion of the chairperson.

This rule is intended to implement Iowa Code section 904.803.

201—37.5(904) Private sector employment projects.

37.5(1) *Definitions.*

"Advisory board" means the prison industries advisory board.

"Deputy director of prison industries" means the department of corrections deputy director responsible for the day-to-day operations of prison industries including private sector individuals.

"Director" means the chief executive officer of the department of corrections.

"Workforce development board" means the state workforce development board.

"Workforce development director" means the chief executive officer of the department of workforce development.

37.5(2) *Preapplication requirement.* Prior to submitting an application to the deputy director of prison industries for a private sector employment project, the employer shall place a job order with a duration of at least 30 days with the nearest workforce development center. The job order will contain the prevailing wage determined by workforce development. The job order shall be listed statewide in all centers and on the department of workforce development's jobs Internet site.

37.5(3) *Employer application.*

a. Private sector employers requesting offender labor must submit the following to the deputy director of prison industries:

1. Work program, including job description;
2. Proposed wage rate;
3. Description of job site;
4. Duration of the work; and
5. Copy of the job order listing with workforce development.

b. Upon receiving a written proposal to use offenders in a private sector work program, the deputy director of prison industries shall provide a copy of the private sector work proposal including job descriptions and proposed wages to the workforce development director.

c. The deputy director of prison industries shall send a letter to the department of workforce development requesting verification of the employer's 30-day job listing, the average wage rate for the job(s) the offenders will perform, the current unemployment rate in the county where the employer is located, and the current employment level of the company that will employ the offenders.

d. The deputy director of prison industries and the warden/superintendent at the proposed institution shall review the proposed projects with the board of supervisors and the sheriff in the county where the project will be located.

37.5(4) *Verification.* The workforce development director shall verify the employment levels and prevailing wages paid for similar jobs in the area and provide to the deputy director of prison industries in writing:

1. Verification of the employer's 30-day job listing;
2. The number of qualified applicant referrals and hires made as a result of the job order;
3. The average wage rate for the proposed job(s);
4. The wage range;
5. The current unemployment rate for the county where the employer is located; and
6. The current employment levels of the company that will employ the offenders based upon the most recent quarter for which data is available.

37.5(5) *Prevailing wages.* The deputy director of prison industries shall obtain employment levels in the locale of the proposed job(s) and the prevailing wages for the job(s) in question from the department of workforce development prior to authorizing any private sector work program. The deputy director of prison industries will consider the average wage rate and wage range from the department of workforce development for the appropriate geographic area for which occupational wage information is available. The appropriate geographic area may be statewide.

To reduce possible displacement of civilian workers, the deputy director of prison industries shall advise prospective employers and eligible offenders of the following requirements:

1. Offenders shall not be eligible for unemployment compensation while incarcerated.
2. Before the employer initiates work utilizing offender labor, the deputy director of prison industries shall provide the baseline number of jobs as established by the department of workforce development.
3. In January and July of each year, the deputy director of prison industries shall receive from the department of workforce development the actual number of civilian workers by employer and shall compile a side-by-side comparison for each employer. A copy of the side-by-side comparison will be provided to the advisory board and workforce development director semiannually.

37.5(6) *Ineligible projects.* The deputy director of prison industries shall evaluate the information from the department of workforce development to verify nondisplacement of civilian workers. Employment of offenders in private industry shall not displace employed workers, apply to skills, crafts, or trades in which there is a local surplus of labor, or impair existing contracts for employment or services.

37.5(7) *Notification.* The deputy director of prison industries shall provide a copy of the private sector work proposal and the department of workforce development review of the private sector work proposal to the following:

1. Governor's office;
2. Speaker of the house;
3. President of the senate;
4. Warden/superintendent at the proposed work site;
5. Local labor organization(s);
6. Director of workforce development; and
7. Department of Justice, Washington, DC.

Within 14 calendar days of receiving the department of workforce development review, the deputy director of prison industries will consolidate the recommendations for review and approval by the director of corrections.

37.5(8) *Prison industries advisory board review.* Following approval by the director of corrections, the deputy director of prison industries shall forward the final proposal to the prison industries advisory board with the recommendation to approve or disapprove the work program, including all correspondence from the department of workforce development, the Department of Justice, and any local official who has offered comments.

The deputy director of prison industries shall provide written documentation to the prison industries advisory board confirming that the proposed work project will not displace civilian workers. If displacement occurs, the deputy director of prison industries shall advise the private employer that the employer will be given 30 days to become compliant or the department of corrections will terminate the use of offender labor.

37.5(9) *Disputes.* Anyone who believes that the private sector work program violates this rule shall advise the department of workforce development. A written complaint may be filed in accordance with workforce development board rule 877—1.5(84A). The workforce development director shall consult with the deputy director of prison industries before the workforce development board makes a final recommendation(s) to resolve any complaint.

The deputy director of prison industries will assist the department of workforce development in compiling all information necessary to resolve the dispute. The workforce development board shall notify the deputy director of prison industries and interested parties in writing of the recommended action to resolve a complaint, which will be binding on all parties.

This rule is intended to implement Iowa Code section 904.809.

201—37.6(904) Utilization of offender labor in construction and maintenance projects.

37.6(1) *Definitions.*

"Director" means the chief executive officer of the department of corrections.

"Employer" means a contractor or subcontractor providing maintenance or construction services under contract to the department of corrections or under the department of general services.

"Workforce development director" means the chief executive officer of the department of workforce development.

37.6(2) *Scope.* Utilization of offender labor applies only to contractors or subcontractors providing construction or maintenance services to the department of corrections. The contract authority for providing construction or maintenance services may be the department of general services.

37.6(3) *Employer application.* Employers working under contract with the state of Iowa may submit an application to the department of corrections to employ offenders. Requests for such labor shall not include work release offenders assigned to community-based corrections under Iowa Code chapter 905.

a. Prior to submitting an application, the employer shall place with the nearest workforce development center a job order with a duration of at least 30 days. The job order will contain the prevailing wage determined by the department of workforce development. The job order shall be listed statewide in all centers and on the department of workforce development's jobs Internet site.

b. The employer's application shall include:

1. Scope of work, including type of work and required number of workers;
2. Proposed wage rate;
3. Location;
4. Duration; and
5. Reason for utilizing offender labor.

c. The department of corrections shall verify through the department of workforce development the employer's 30-day job listing, the average wage rate for the job(s) the offenders will perform, the current unemployment rate in the county where the employer is located, and the current employment level of the employer that will employ the offenders.

37.6(4) *Verification.* The director of workforce development shall verify the employment levels and prevailing wages paid for similar jobs in the area and provide to the director, in writing:

1. Verification of the employer's 30-day job listing;
2. The number of qualified applicant referrals and hires made as a result of the job order;
3. The average wage rate for the proposed job(s);
4. The wage range;
5. The prevailing wage as determined by the U.S. Department of Labor;
6. The current unemployment rate for the county where the employer is located;
7. The current employment levels of the employer that will employ the offenders based upon the most recent quarter for which data is available.

37.6(5) *Safety training.* The employer shall document that all offenders employed in construction and maintenance projects receive a 10-hour OSHA safety course provided free of charge by the department of workforce development.

37.6(6) *Prevailing wages.* The director will not authorize an employer to employ offenders in hard labor programs without obtaining from the department of workforce development employment levels in the locale of the proposed jobs and the prevailing wages for the jobs in question. The average wage rate and wage range from the department of workforce development will be based on the appropriate geographic area for which occupational wage information is available. The appropriate geographic area may be statewide.

To reduce any potential displacement of civilian workers, the director shall advise prospective employers and eligible offenders of the following requirements:

1. Offenders will not be eligible for unemployment compensation while incarcerated.
2. Before the employer initiates work utilizing offender labor, the director shall provide the baseline number of jobs as established by the department of workforce development.
3. If the contract to employ offender labor exceeds six months, the director shall request and receive from the workforce development director the average wage rates and wage ranges for jobs currently held by offenders and current employment levels of employers employing offenders and shall compile a side-by-side comparison of each employer.

37.6(7) *Disputes.* Anyone who believes that the employer's application violates this rule shall present concerns in writing to the workforce development board. A written complaint may be filed with the workforce development board for any dispute arising from the implementation of the employer's application in accordance with the workforce development board's rule 877—1.6(84A). The workforce development board shall consult with the director prior to making recommendations. The director will assist the workforce development board in compiling all information necessary to resolve the dispute. The workforce development board shall notify the director and interested parties in writing of the corrective action plan to resolve the dispute, which will be binding on all parties.

This rule is intended to implement Iowa Code section 904.701.

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[Filed 6/9/00, Notice 4/5/00—published 6/28/00, effective 8/2/00]◊

*Prior to 3/20/91, see Prison Industries Advisory Board 635—Chapter 1
◊Two ARCs

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CHAPTER 14
EXECUTIVE CLEMENCY
[615—Ch 14 transferred to 205—Ch 5, IAB 2/22/89]

205—14.1(902) Interviews of inmates serving life terms. The board shall not grant a parole or work release to a Class "A" felon serving a life term unless the governor commutes the sentence to a term of years. Administrative rules relating to the parole and work release consideration of an inmate sentenced to an indeterminate term shall not apply to an inmate sentenced to a life term. The board shall interview a Class "A" felon serving a life term to determine whether to recommend that the governor commute the sentence to a term of years. The board shall recommend that the governor commute the sentence when the board concludes that the inmate should be considered for release on parole or work release. In making such a recommendation, the board shall also indicate the existence of any registered victims, and communicate any opinions expressed by those victims regarding release of the inmate.

205—14.2(902) Review of inmates serving life terms. Rescinded IAB 6/28/00, effective 6/8/00.

205—14.3(248A) Executive clemency applications.

14.3(1) *Applications to the board.*

a. A person convicted of a criminal offense may apply to the board for a recommendation to the governor for a reprieve, pardon, commutation of sentence, or remission of fines and forfeitures at any time following the person's conviction.

b. An application for a pardon or commutation of sentence shall be on the form provided by the board. The form may be obtained by contacting the board business office.

c. An application for a reprieve or remission of fines and forfeitures shall be in writing.

d. The applicant shall submit the executive clemency application to the board business office.

14.3(2) *Applications to the governor.* Upon the request of the governor, the board shall take charge of all correspondence in reference to an executive clemency application filed with the governor and shall provide the governor with the board's advice and recommendation.

14.3(3) *Restoration of citizenship.*

a. A person convicted of a criminal offense may apply for a restoration of citizenship at any time following the discharge of the person's sentence.

b. A person applying for restoration of citizenship within 60 days of discharge of the person's sentence shall submit the short form Application for Restoration of Citizenship, together with an original of a progress report from the supervising agent, to the board. This form may be obtained from the supervising officer. The board shall submit a recommendation to the governor regarding restoration of citizenship.

c. A person applying for restoration of citizenship more than 60 days after discharge of the person's sentence shall submit the Executive Clemency Application form to the governor. This form may be obtained from the governor's office or from the board. The governor shall obtain a recommendation regarding restoration of citizenship from the board.

205—14.4(248A,902) Board investigation. The board may investigate an application or district department recommendation with respect to history, current situation, parole prospects and other pertinent matters. The board may consider the application or recommendation, transcripts of judicial proceedings and all documents submitted with the application, and other documents as the board determines is appropriate and may interview public officials, victims, and witnesses, and other individuals as the board determines is appropriate.

205—14.5(248A,902) Executive clemency recommendations.

14.5(1) *Decision.* Rescinded IAB 6/28/00, effective 6/8/00.

14.5(2) *Notice of board recommendation.* The board shall give notice of an executive clemency recommendation to the office of the governor and, if requested, to the inmate or applicant.

14.5(3) *Board consideration following commutation.* The board shall consider the parole and work release prospects of an inmate whose sentence has been commuted by the governor.

14.5(4) *Executive clemency reconsiderations.*

a. The board may reconsider at any time a board recommendation to grant executive clemency that the governor has denied and returned to the board. The procedures for reviewing an executive clemency application shall apply to the reconsideration of a denied recommendation.

b. The board may refile the recommendation with the governor or withdraw the recommendation.

205—14.6(902) Commutation procedure for class "A" felons.

14.6(1) *Initial review.* The board of parole, or its designee, will initially review an application for commutation to determine whether the inmate is eligible for a commutation pursuant to Iowa Code section 902.2. If the inmate is not eligible to apply for commutation pursuant to Iowa Code section 902.2, the board shall return the application to the governor and notify the governor of the reasons.

14.6(2) *Parole board commutation investigation process.*

a. If the applicant is eligible to apply for commutation pursuant to Iowa Code section 902.2, the board shall conduct an investigation pursuant to that section and subrule 14.6(2).

b. The board may consider any documents the board deems appropriate including, but not limited to, the application and attached documents, transcripts of judicial proceedings, corrections information, and written recommendations, statements, and interviews of public officials, victims, and witnesses.

c. The board shall interview the applicant, pursuant to Iowa Code section 902.2, prior to submitting its recommendation to the governor. The board may interview any other person the board deems appropriate including, but not limited to, public officials, victims, and witnesses. The board may conduct any interview, including the interview of the applicant, through electronic means.

d. The board shall attempt to provide notice of the commutation investigation to any individual who would qualify as a victim under Iowa's victim's notification law. Notice shall be by regular mail to the last-known address. The notice shall provide a specified amount of time for the victim to provide a statement to the board regarding the application for commutation.

e. The board may utilize the resources of the department of public safety for assistance with any part of its investigation.

f. The board may hold a public hearing to receive comments from the general public on an application for commutation. The determination to hold a public hearing to receive public comments is solely at the discretion of the board.

14.6(3) *Recommendation and report.*

a. The board shall vote on a recommendation regarding the application. Any decision to recommend commutation shall be by unanimous vote. The board may continue the matter until such time as the board may determine by majority vote.

b. The board may consider any factor it deems appropriate when considering commutation including, but not limited to, the nature and circumstances of the crime, the number of years the applicant has served, the applicant's previous criminal record, the applicant's conduct while confined, the impact on the victim, and the public interest.

c. The board shall prepare a written report of its findings and recommendations and forward its report to the governor.

14.6(4) *Board consideration following commutation.* The board shall consider the parole and work release prospects of any inmate whose life sentence has been commuted by the governor. The grant of commutation does not require the board to grant parole or work release. The board shall consider parole or work release pursuant to the standards in 205—Chapter 8.

These rules are intended to implement Iowa Code sections 902.2, 902.4, 904A.4(7) and chapter 914.

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(Effective August 31, 2001)

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CHAPTER 15
REQUIREMENTS FOR SPECIAL EDUCATION ENDORSEMENTS

[Prior to 9/7/88, see Education Department[281] Ch 73]
[Prior to 10/3/90, see Education Department[281] Ch 81]

282—15.1(272) Special education teaching endorsements.

15.1(1) *Program requirements.*

a. Baccalaureate or master's degree from a regionally accredited institution.

b. Completion of an approved human relations component.

c. Professional education core: completed coursework or evidence of competency in:

(1) Structure of American education.

(2) Philosophies of education.

(3) Professional ethics and legal responsibilities.

(4) Psychology of teaching.

(5) Audiovisual/media/computer technology.

(6) Human growth and development related to the grade level endorsement desired.

(7) Completion of pre-student teaching field-based experiences in special education.

d. Student teaching. Each applicant for an Iowa license with a special education instructional endorsement must file evidence of completing an approved student teaching program in special education. This experience must be full-time in an approved special education classroom. An approved special education classroom is one which is recognized by the state in terms of the respective state rules for special education.

This special education student teaching experience shall qualify for each special education instructional endorsement sought on an original application for Iowa licensure if at the same grade level.

15.1(2) *Adding special education instructional endorsements to Iowa licenses.* After the issuance of a practitioner license, an individual may add other special education instructional endorsements to that license upon proper application provided current requirements for the endorsement(s) have been met. However, if an applicant is seeking to add a special education instructional endorsement at the same level, elementary or secondary, as other endorsements held, the student teaching component set out in the rules for added endorsement areas is not required.

However, if the applicant seeks to add an endorsement at a different level, that is, from elementary to secondary or from secondary to elementary, the required student teaching at the other level must be completed.

282—15.2(272) Specific requirements. For each of the following teaching endorsements in special education, the applicant must have completed 24 semester hours in special education.

15.2(1) *Behavioral disorders.*

a. Prekindergarten-kindergarten behavioral disorders. Meet the requirements for the early childhood—special education endorsement (refer to 15.2(9)) and complete coursework in:

(1) K-12 introduction/characteristics of behavioral disorders.

(2) A K-6 methods course specific to behavioral disorders.

b. K-6 behavioral disorders.

(1) K-12 introduction/characteristics of behavioral disorders to include etiology of the disability, a historical perspective of its treatment, an overview of current trends in the treatment of the disability, and a study of the impact of the disability on the child and family.

(2) A K-6 methods course specific to behavioral disorders to include an understanding of teaching materials appropriate to behavioral disorders and skill in curriculum planning and modification.

(3) A course of a general survey nature in the area of exceptional children.

(4) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(5) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.
2. Methods and strategies for working with parents, regular classroom teachers, support service personnel, paraprofessionals, and other individuals involved in the education program.

(6) Student teaching specifically in a behavioral disorders K-6 categorical program.

c. 7-12 behavioral disorders.

(1) Same as K-6 behavioral disorders except that methods and student teaching must be 7-12 instead of K-6.

(2) A course in career-vocational programming for special education students.

15.2(2) *Mental disabilities: mild/moderate.*

a. Prekindergarten-kindergarten mental disabilities. Meet the requirements for early childhood—special education. Refer to 15.2(9).

b. K-6 mental disabilities: mild/moderate.

(1) K-12 introduction/characteristics of mental disabilities to include the etiology of the disability, a historical perspective of its treatment, an overview of current trends in the treatment of the disability, and a study of the impact of the disability on the child and family.

(2) K-6 curriculum, methods and materials course for students with mild mental disabilities (to include the concepts of career-vocational education, transition, and integration).

(3) K-12 functional, age-appropriate, longitudinal curriculum development (life skills) course for students with moderate mental disabilities which should include:

1. Assessment and evaluation.
2. Instructional methodology.
3. Integration and social interactions in regular schools and community environments.
4. Transition process from school to community environments.
5. Career-vocational programming.

(4) A course of a general survey nature in the area of exceptional children.

(5) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(6) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.
2. Methods and strategies for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(7) K-6 student teaching in a mild or in a moderate mental disabilities categorical program.

c. 7-12 mental disabilities: mild/moderate.

(1) Same as K-6 mental disabilities except that the mild methods and the mild or moderate student teaching must be completed at the 7-12 level instead of K-6.

(2) A course in career-vocational programming for special education students.

15.2(3) *Mental disabilities: severe and profound.* The holder of this endorsement is authorized to teach students with severe and profound multiple handicaps from the age of 5 to the age of 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

a. Prekindergarten-kindergarten mental disabilities. Meet the requirements for early childhood—special education. Refer to 15.2(9).

b. K-12 mental disabilities: severe and profound.

(1) K-12 introduction/characteristics of mental disabilities to include the etiology of the disability, a historical perspective of its treatment, an overview of current trends in the treatment of the disability, and a study of the impact of the disability on the child and family.

(2) K-12 functional, age-appropriate, longitudinal curriculum development (life skills) course for students with severe and profound multiple handicaps which should include:

1. Assessment and evaluation.
2. Instructional methodology covering adaptations and the concept of partial participation.
3. Integration and social interactions in regular schools and community environments.
4. Transition process from school to community environments.
5. Career-vocational programming.

(3) A course of a general survey nature in the area of exceptional children.

(4) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom strategies.
2. Methods and strategies for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(5) K-6 or 7-12 student teaching experience with students with severe and profound multiple handicaps.

15.2(4) *Learning disabilities.*

a. K-6 learning disabilities.

(1) A K-12 introductory course of learning disabilities that includes a historical perspective to the field's development, characteristics and etiology, definitions and identification procedures, conceptual orientations, treatment and intervention, impact of the disability on the individual and family, and current trends and issues.

(2) A K-6 instructional methods and strategies course specific to learning disabilities that at least covers the areas of reading, written expression, listening comprehension, oral language, mathematics, independent student behaviors, social skills, and curriculum development.

(3) At least one of the following courses:

1. Methods in remedial reading.
2. Methods in remedial mathematics.
3. Language and language disorders.
4. Methods in behavioral disorders.

(4) A course of a general survey nature in the area of exceptional children.

(5) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(6) Coursework or evidence of competency in:

1. A course in individual behavioral management, behavioral change strategies, and classroom management.

2. A methods and strategies course for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(7) Student teaching specifically in a K-6 learning disabilities categorical program.

b. 7-12 learning disabilities.

(1) Same as K-6 learning disabilities except that instructional methods and strategies course and student teaching must be 7-12 instead of K-6.

(2) A course in career-vocational programming for special education students.

15.2(5) *Physically handicapped.*

a. Prekindergarten-kindergarten physically handicapped. Meet the requirements for early childhood—special education. Refer to 15.2(9).

b. K-6 physically handicapped.

(1) K-6 introduction/characteristics of physically handicapped to include the etiology of the disability, a historical perspective of its treatment, an overview of current trends in the treatment of the disability, and a study of the impact of the disability on the child and family.

(2) A K-6 methods course specific to physically handicapped to include an understanding of teaching materials appropriate to the physically handicapped and skill in curriculum planning and modification.

(3) A course of a general survey nature in the area of exceptional children.

(4) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(5) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.

2. Methods and strategies for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(6) Student teaching specifically in a K-6 physically handicapped categorical program.

c. 7-12 physically handicapped.

(1) Same as K-6 physically handicapped except that methods and student teaching must be 7-12 instead of K-6.

(2) A course in career-vocational programming for special education.

15.2(6) *Hearing impaired.*

a. Prekindergarten-kindergarten hearing impaired. Meet the requirements for the K-6 hearing impaired endorsement and complete coursework in:

(1) Curriculum development and instructional methods for working with young hearing-impaired children (birth through age six).

(2) A course specific to using various communication systems with hearing-impaired children.

(3) The education of hearing-impaired infants and their parents to include the parent-infant relationship, parent training, social/economic issues affecting the family, and development of model parent-infant programs.

(4) A student teaching experience or practicum with hearing-impaired children (birth through age six).

b. K-6 hearing impaired.

(1) Anatomy and physiology of the hearing mechanism.

(2) Language development and disorders.

(3) Teaching academic subjects to the hearing impaired.

(4) Teaching language and speech to the deaf/hearing impaired.

(5) A course in the use of sign language for the hearing impaired.

(6) A course of a general survey nature in the area of exceptional children.

(7) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(8) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.
2. Methods and strategies for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.
3. Understanding the multiply handicapped child.

(9) Student teaching specifically in a hearing-impaired K-6 categorical program.

c. 7-12 hearing impaired.

(1) Same as K-6 hearing impaired except that student teaching must be 7-12 instead of K-6.

(2) A course in career-vocational programming for special education students.

d. Itinerant teacher—hearing impaired. The holder of this endorsement is authorized to serve as an itinerant teacher with children from birth to 21 years (and to a maximum allowable age in accord with Iowa Code section 256B.8). The applicant shall have met the requirements for one of the above endorsements and in addition thereto the following coursework:

(1) Effective techniques for working with families of preschool handicapped children.

(2) Consultation processes in special education.

15.2(7) *Visually impaired.*

a. Prekindergarten-kindergarten visually impaired. Meet the requirements for early childhood—special education. Refer to 15.2(9).

b. K-6 visually impaired.

(1) Anatomy and physiology of the visual mechanism.

(2) Introduction to instruction of the visually impaired.

(3) Braille.

(4) Techniques of instruction for the visually impaired.

(5) A course of a general survey nature in the area of exceptional children.

(6) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(7) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.
2. Methods and strategies for working with parents, regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.
3. Understanding the multiply handicapped child.
4. Knowledge of latest technology when working with visually impaired.

(8) Student teaching in K-6 categorical visually impaired program.

c. 7-12 visually impaired.

(1) Same as K-6 visually impaired except that student teaching must be 7-12 instead of K-6.

(2) A course in career-vocational programming for special education students.

d. Itinerant teacher—visually impaired. The holder of this endorsement is authorized to serve as an itinerant teacher with children from birth to 21 years (and to a maximum allowable age in accord with Iowa Code section 256B.8). The applicant shall have met the requirements for one of the above endorsements and in addition thereto the following coursework:

(1) Effective techniques for working with families of preschool handicapped children.

(2) Consultation processes in special education.

15.2(8) *Multicategorical resource teacher—mildly handicapped.*

a. Option 1—K-6 multicategorical resource. The holder of this endorsement must meet the requirements to serve as a teacher of the nonhandicapped. See rule 282—14.18(272).

(1) A K-12 introductory course for providing educational services to the mildly disabled youngsters in multicategorical programs which should include current trends and issues for serving these youngsters, basic theoretical and practical approaches, educational alternatives, implication of federal and state statutes and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming.

(2) A K-6 methods and strategies course which includes numerous models for providing curricular and instructional methodologies utilized in the education of the mildly handicapped.

(3) Two strategy courses chosen from the following list:

1. A methods course for mental disabilities.
2. A methods course for learning disabilities.
3. A methods course for behavioral disorders.
4. A course in remedial reading.
5. A course in remedial mathematics.

(4) A course of a general survey nature in the area of exceptional children.

(5) A course or courses in the collection and use of academic and behavioral data for the educational diagnosis, assessment, and evaluation of special education pupils which should include:

1. Norm-referenced instruments (including behavioral rating measures).
2. Criterion-referenced instruments.
3. Ecological assessment techniques.
4. Systematic observation.
5. Individual trait or personality assessments.
6. Social functioning data.
7. Application of assessment results to individualized program development and management.

(6) Coursework or evidence of competency in:

1. Individual behavioral management, behavioral change strategies, and classroom management.
2. Methods and strategies for working with parents, support services personnel, regular classroom teachers, paraprofessionals, and other individuals involved in the educational program.

(7) Student teaching in a K-6 multicategorical resource room—mildly handicapped.

b. Option 1—7-12 multicategorical resource.

(1) The holder of this endorsement must meet the requirements to serve as a teacher of the nonhandicapped. See rule 282—14.18(272).

(2) Same as K-6 except that student teaching and the instructional strategies course for the multicategorical resource room must be 7-12 instead of K-6.

(3) A course in career-vocational programming for special education students.

c. Option 2—K-6 multicategorical resource. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-6 or 7-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out above in 15.2(8)*"a"*(1) through (7).

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children, unless completed as part of the professional education core. See 282—subrule 14.19(3).

(2) Methods of and materials for teaching elementary language arts.

(3) Remedial reading.

(4) Elementary curriculum methods and materials, unless completed as part of another elementary level endorsement program (e.g., 282—subrule 14.20(2), 14.20(3), or 14.20(12) or a similar elementary endorsement program).

(5) Methods of and materials for teaching elementary mathematics.

d. Option 2—7-12 multicategorical resource. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-6 or 7-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out above in 15.2(8)*"a"*(1) through (6).

(1) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children, unless completed as part of the professional education core. See 282—subrule 14.19(3).

(2) Adolescent literacy or secondary content area reading.

(3) Secondary or adolescent reading diagnosis and remediation.

(4) Methods of and materials for teaching adolescents with mathematics difficulties or mathematics for the secondary level learning disabilities teacher.

(5) Secondary methods unless completed as part of the professional education core. See 282—subrule 14.19(3).

(6) Student teaching and the instructional strategies course for the multicategorical resource room must be 7-12 instead of K-6.

(7) A course in career-vocational programming for special education students.

15.2(9) *Early childhood—special education.*

a. A course of a general survey nature in the area of exceptional children.

b. Coursework specifically focused on special education children from conception to age three which should include:

(1) Development.

(2) Screening, assessment, and evaluation.

(3) Service delivery models.

(4) Curriculum, including behavior management.

(5) Working with adult learners.

(6) Pre-student teaching field experience in home instruction programs.

c. Coursework specifically focused on special education children from age three to six which should include:

(1) Development.

(2) Screening, assessment, and evaluation.

(3) Service delivery models.

(4) Curriculum, including behavior and classroom management.

(5) Pre-student teaching field experience to include severely or multiply handicapped.

d. A course which focuses on specific strategies for working with adult learners and family systems.

e. A course specific to communication development and information on alternative communication systems for special education children.

f. A course specific to methods and materials for working with young children with severe/profound or multiple disabilities to include medical issues, exercises in problem solving specific to adaptations of materials, equipment and programs, and utilization of human resources.

g. A course which focuses on working with others which explores in depth the myriad of related service agencies at the federal, state, and local levels which may be needed to appropriately serve young children and their families who may be categorized as medically fragile, disadvantaged, handicapped, in need of respite services, or from single-parent families.

h. A course in cardiopulmonary resuscitation and first-aid training.

i. Adequate preparation in methods and techniques for working with the medically fragile and technologically dependent children.

j. A student teaching experience in an early childhood special education program.

15.2(10) *Multicategorical special class with integration.*

a. Prekindergarten-kindergarten multicategorical special class with integration. Meet the requirements for the following endorsement: early childhood—special education. Refer to 15.2(9).

b. K-6 multicategorical special class with integration. Meet the requirements for two of the following endorsements:

(1) K-6 behavioral disorders.

(2) K-6 mental disabilities.

1. Mild/moderate, or
2. Moderate/severe/profound.

(3) K-6 learning disabilities.

(4) One of the endorsements may include:

1. K-6 physically handicapped.
2. K-6 hearing impaired.
3. K-6 visually impaired.

c. 7-12 multicategorical special class with integration. Same as K-6 except the grade level must be 7-12.

If all of the requirements for two endorsements are met with the exception of the student teaching experiences, one student teaching experience in a multicategorical special class with integration program may be completed.

15.2(11) *Speech and language teacher.* Reserved.

15.2(12) *Instructional endorsement.* Applicants for a special education instructional endorsement may present evidence of three years' successful teaching experience in the type of assignment authorized by the endorsement to appear on the license sought in lieu of the credits in student teaching required for the endorsement, provided the following three conditions are met:

a. The three years of experience to be substituted for student teaching shall have been gained on a valid license or certificate other than a temporary or emergency certificate or license.

b. A corresponding number of semester hours of credit is presented in other special education courses, and

c. The institution recommending the applicant for such endorsement agrees to the substitution.

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◊Two ARCs
*Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held September 9, 1992; delay lifted by the Committee October 14, 1992, effective October 15, 1992.

CHAPTER 22
PARAEDUCATOR CERTIFICATES

282—22.1(272) Paraeducator certificates. Iowa paraeducator certificates are issued upon application filed on a form provided by the board of educational examiners.

282—22.2(272) Approved paraeducator certificate programs. An applicant for an initial paraeducator certificate who completes the paraeducator preparation program from a recognized Iowa paraeducator approved program shall have the recommendation from the designated certifying official at the recognized area education agency, local education agency, community college, or institution of higher education where the preparation was completed. A recognized Iowa paraeducator approved program is one which has its program of preparation approved by the state board of education according to standards established by the board.

282—22.3(272) Issue date on original certificate. A certificate is valid only from and after the date of issuance.

282—22.4(272) Validity. The paraeducator certificate shall be valid for five years.

282—22.5(272) Certificate fee.

22.5(1) *Issuance of certificates.* The fee for the issuance of the paraeducator certificate shall be $25.

22.5(2) *Adding areas of concentration.* The fee for the addition of each area of concentration to a paraeducator certificate, following the issuance of the initial paraeducator certificate and any area(s) of concentration, shall be $10.

282—22.6(272) Prekindergarten through grade 12 paraeducator generalist certificate.

22.6(1) Applicants must possess a minimum of a high school diploma or a graduate equivalent diploma.

22.6(2) Applicants shall be disqualified for any of the following reasons:

a. The applicant is less than 18 years of age.

b. The applicant has been convicted of child abuse or sexual abuse of a child.

c. The applicant has been convicted of a felony.

d. The applicant's application is fraudulent.

e. The applicant's certification from another state is suspended or revoked.

f. The applicant fails to meet board standards for application for an initial or renewed certificate.

22.6(3) Qualifications or criteria for the granting or revocation of a certificate or the determination of an individual's professional standing shall not include membership or nonmembership in any teacher or paraeducator organization.

22.6(4) Applicants shall have successfully completed at least 90 clock hours of training in the areas of behavior management, exceptional child and at-risk child behavior, collaboration skills, interpersonal relations skills, child and youth development, technology, and ethical responsibilities and behavior.

22.6(5) Applicants shall have successfully completed the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Support a safe, positive teaching and learning environment including the following competencies:

(1) Follow prescribed health, safety, and emergency school and classroom policy and procedures.

(2) As directed, prepare and organize materials to support teaching and learning.

(3) Use strategies and techniques for facilitating the integration of individuals with diverse learning needs in various settings.

(4) Assist with special health services.

(5) Assist in adapting instructional strategies and materials according to the needs of the learner.

(6) Assist in gathering and recording data about the performance and behavior of individuals.

(7) Assist in maintaining a motivational environment.

(8) Assist in various instructional arrangements (e.g., large group, small group, tutoring).

b. Assist in the development of physical and intellectual development including the following competencies:

(1) Assist with the activities and opportunities that encourage curiosity, exploration, and problem solving that are appropriate to the development levels and needs of all children.

(2) Actively communicate with children and provide opportunities and support for children to understand, acquire, and use verbal and nonverbal means of communicating thoughts and feelings.

(3) Actively communicate and support high expectations that are shared, clearly defined and appropriate.

(4) Make and document observations appropriate to the individual with specific learning needs.

(5) Use strategies that promote the learner's independence.

(6) Assist in monitoring progress and providing feedback to the appropriate person.

c. Support social, emotional, and behavioral development including the following competencies:

(1) Provide a supportive environment in which all children, including children with disabilities and children at risk of school failure, can begin to learn and practice appropriate and acceptable behaviors as individuals and groups.

(2) Assist in developing and teaching specific behaviors and procedures that facilitate safety and learning in each unique school setting.

(3) Assist in the implementation of individualized behavior management plans, including behavior intervention plans for students with disabilities.

(4) Model and assist in teaching appropriate behaviors as a response to inappropriate behaviors.

(5) Use appropriate strategies and techniques in a variety of settings to assist in the development of social skills.

(6) Assist in modifying the learning environment to manage behavior.

d. Establish positive and productive relations including the following competencies:

(1) Demonstrate a commitment to a team approach to interventions.

(2) Maintain an open, friendly, and cooperative relationship with each child's family, sharing information in a positive and productive manner.

(3) Communicate with colleagues, follow instructions and use problem-solving skills that will facilitate working as an effective member of the school team.

(4) Foster respectful and beneficial relationships between families and other school and community personnel.

(5) Function in a manner that demonstrates a positive regard for the distinctions among roles and responsibilities of paraprofessionals, professionals, and other support personnel.

e. Integrate effectively the technology to support student learning including the following competencies:

(1) Establish an environment for the successful use of educational technology.

(2) Support and strengthen technology planning and integration.

(3) Improve support systems for technical integration.

(4) Operate computers and use technology effectively.

f. Practice ethical and professional standards of conduct on an ongoing basis including the following competencies:

(1) Demonstrate a commitment to share information in a confidential manner.

(2) Demonstrate a willingness to participate in ongoing staff development and self-evaluation, and apply constructive feedback.

(3) Abide by the criteria of professional practice and rules of the board of educational examiners.

22.6(6) An applicant for a certificate under these rules shall demonstrate that the requirements of the certificate have been met, and the burden of proof shall be on the applicant.

282—22.7(272) Paraeducator area of concentration. An area of concentration is not required but optional. Applicants must currently hold or have previously held an Iowa paraeducator generalist certificate. Applicants may complete one or more areas of concentration but must complete at least 45 clock hours in each area of concentration.

22.7(1) *Early childhood—prekindergarten through grade 3.* The paraeducator shall successfully complete the following list of competencies so that under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Reinforce skills, strategies, and activities involving individuals or small groups.

b. Participate as a member of the team responsible for developing service plans and educational objectives for parents and their children.

c. Listen to and communicate with parents in order to gather information for the service delivery team.

d. Demonstrate knowledge of services provided by health care providers, social services, education agencies, and other support systems available to support parents and provide them with the strategies required to gain access to these services.

e. Demonstrate effective strategies and techniques to stimulate cognitive, physical, social, and language development in the student.

f. Gather information as instructed by the classroom teacher about the performance of individual children and their behaviors, including observing, recording, and charting, and share information with professional colleagues.

g. Communicate and work effectively with parents and other primary caregivers.

22.7(2) *Special needs—prekindergarten through grade 12.* The paraeducator shall successfully complete the following list of competencies so that under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Understand and implement the goals and objectives in an individualized education plan (IEP).

b. Demonstrate an understanding of the value of serving children and youth with disabilities and special needs in inclusive settings.

c. Assist in the instruction of students in academic subjects using lesson plans and instructional strategies developed by teachers and other professional support staff.

d. Gather and maintain data about the performance and behavior of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

e. Use appropriate instructional procedures and reinforcement techniques.

f. Operate computers, use assistive technology and adaptive equipment that will enable students with special needs to participate more fully in general education.

22.7(3) *English as a second language—prekindergarten through grade 12.* The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Operate computers and use technology that will enable students to participate effectively in the classroom.

b. Work with the classroom teacher as collaborative partners.

c. Demonstrate knowledge of the role and use of primary language of instruction in accessing English for academic purposes.

d. Demonstrate knowledge of instructional methodologies for second language acquisition.

e. Communicate and work effectively with parents or guardians of English as a second language students in their primary language.

f. Demonstrate knowledge of appropriate translation and interpretation procedures.

22.7(4) *Career and transitional programs—grades 5 through 12.* The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Assist in the implementation of career and transitional programs.

b. Assist in the implementation of appropriate behavior management strategies for career and transitional students and those students who may have special needs.

c. Assist in the implementation of assigned performance and behavior assessments including observation, recording, and charting for career and transitional students and those students who may have special needs.

d. Provide training at job sites using appropriate instructional interventions.

e. Participate in preemployment, employment, or transitional training in classrooms or at off-campus sites.

f. Communicate effectively with employers and employees at work sites and with personnel or members of the public in other transitional learning environments.

282—22.8 to **22.11** Reserved.

282—22.12(272) Prekindergarten through grade 12 advanced paraeducator certificate. Applicants for the prekindergarten through grade 12 advanced paraeducator certificate shall have met the following requirements:

22.12(1) Currently hold or have previously held an Iowa paraeducator generalist certificate.

22.12(2) Possess an associate's degree or have earned 62 semester hours of college coursework from a regionally accredited institution of higher education.

22.12(3) Complete a minimum of two semester hours of coursework involving at least 100 clock hours of a supervised practicum with children and youth. These two semester hours of practicum may be part of an associate degree or part of the earned 62 semester hours of college coursework.

282—22.13(272) Renewal requirements. The paraeducator certificate may be renewed upon application, a $25 renewal fee, and verification of successful completion of coursework totaling three units in any combination listed below.

1. One unit may be earned through a planned staff development renewal course related to paraeducators in accordance with guidelines approved by the board of educational examiners.
2. One unit may be earned for each semester hour of college credit.

These rules are intended to implement Iowa Code sections 272.6 and 272.12.

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TITLE VIII
MEDICAL ASSISTANCE

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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. Terminated income of recipient households who are subject to retrospective budgeting beginning with the calendar month the source of the income is absent, provided the absence of the income is timely reported as described at 441—subrule 40.24(1) and 441—subparagraph 40.27(4)*"f"*(1).

EXCEPTION: Income that terminated in one of the two initial months occurring at time of an initial application that was not used prospectively shall be considered retrospectively as required by 41.27(9)*"b"*(1). If income terminated and is timely reported but a grant adjustment cannot be made effective the first of the next month, a payment adjustment shall be made. This subrule shall not apply to nonrecurring lump sum income defined at 41.27(9)*"c"*(2).

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 for Census 2000 during the period of April 1, 2000, through January 31, 2001.

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) Treatment of income when the parent is a citizen or an alien other than those described in 41.23(4)*"a"*(3). 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 20 percent earned income deduction, the 50 percent work incentive deduction described at 41.27(2)*"a"* and *"c,"* and diversions described at 41.27(4), and 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 41.27(11). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

(2) Treatment of income of a parent who is ineligible because of lawful temporary or permanent resident status. The income of a parent who is ineligible as described in 41.23(4)*"a"*(3) shall be attributable to the eligible group in the same manner as the income of a stepparent is determined pursuant to 41.27(8)*"b"*(1) to (7), (9) and (10). Nonrecurring lump sum income received by the parent shall be treated in accordance with 41.27(9)*"c"*(2).

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 natural 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.

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65.29(3) *Exclusion of income from 2000 census employment.* All earnings received by temporary workers from the Bureau of the Census for Census 2000 during the period of April 1, 2000, through January 31, 2001, shall be excluded from income.

65.29(4) *Interest income for retrospectively budgeted cases.* 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.* Notwithstanding anything to the contrary in these rules or regulations, 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). 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. 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.* Notwithstanding anything to the contrary in these rules or regulations, the earnings of elementary or high school students who are members of the household and are 17 years of age or younger shall be excluded.

65.29(8) *Vendor payments.* General assistance vendor payments provided for energy or utility-cost assistance shall also be excluded.

65.29(9) *HUD or FmHA utility reimbursement.* HUD or FMHA utility reimbursement payments shall be excluded from income.

65.29(10) *Welfare reform and regular household honorarium income.* All moneys paid to a food stamp household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

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) *Exclusion from resource limits.* The value of vehicles necessary to carry fuel for heating or water for home use when the transported fuel or water is the primary source of fuel or water for the household shall be excluded.

65.30(3) *Resources of SSI and FIP household members.* Notwithstanding anything to the contrary in these rules or regulations, all resources of SSI or FIP recipients are excluded. For food stamp 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 regulations, earned income tax credits (EITC) shall be excluded from consideration as a resource for 12 months from the date of receipt if the person receiving the EITC was participating in the food stamp program at the time the credits were received, and participated continuously during the 12-month period.

65.30(5) *Vehicles not otherwise excluded.* Notwithstanding anything to the contrary in these rules or regulations, all licensed vehicles not excluded as a resource shall individually be evaluated for fair market value and that portion of the value which exceeds $4,650 shall be attributed in full toward the household's resource level, regardless of any encumbrances on the vehicles.

441—65.31(234) Homeless meal providers. When an office of the department is notified that an establishment or shelter in its administrative area has applied to be able to accept food stamps 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 food stamp allotments. Notwithstanding anything to the contrary in these rules or regulations, the annual adjustment to the maximum allotment shall be based on 100 percent of the Thrifty Food Plan. Allotments shall not fall below the federal fiscal year 1996 level.

441—65.33(234) Maximum monthly dependent care deduction. Notwithstanding anything to the contrary in these rules or regulations, the maximum monthly dependent care deduction households shall be granted is $200 for each child under two years of age and $175 for each other dependent.

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.

65.36(1) *Liability for unauthorized use of food stamp EBT benefits.* The department shall not replace EBT benefits that are lost or stolen after being credited to that household's food stamp account unless the loss occurs after the time the household reports the loss, theft, or compromise of their EBT card or PIN to the department or the electronic funds transfer (EFT) network. The food stamp household is liable for unauthorized use of its EBT card that occurs prior to the time the household reports the loss.

65.36(2) *EBT state guarantee.* In the event that the EBT point of sale (POS) system is inoperable, and the household has incurred an expense using a manual voucher against its food stamp account for eligible food items exceeding the balance in their food stamp account, the state shall pay the retailer the balance in that account. In addition, if the balance of the household's food stamp account is less than $40, the state will pay the retailer the difference between $40 and the balance in the account, up to the amount of the purchase, so that the total payment from food stamp benefits and state guarantee does not exceed $40. Payment will not be made for more than one manual voucher transaction for a cardholder at the same retail establishment in one day.

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*Amendments to subrules 65.30(5) and 65.130(7) and rules 65.32(234) and 65.132(234) effective 10/1/96.
** Subrules 65.8(11) and 65.108(11) effective 1/1/97.

73.4(3) *Income eligibility.* All earned and unearned income of the household shall be counted 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 money wages or salary, net income from nonfarm self-employment, net income from farm self-employment, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, workers' compensation, alimony, child support, veterans' pensions, social security, railroad retirement, supplemental security income, state or federal assistance, veterans' benefits, black lung benefits, all disability pensions, state supplementary assistance, unemployment compensation benefits, and 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. Biweekly income is to be multiplied by 2.15 to determine monthly income. Adjusted gross self-employment income is to be averaged over a 12-month period. Income received from interest and dividends shall be averaged over a 12-month period. The amount of income which stops or starts during the month shall be estimated on the basis of the best information available.

c. Income exclusions. Income from the following programs shall not be counted when figuring total household income for this program:

(1) Uniform Relocation Assistance and Real Property Acquisition Act of 1970 (Public Law 91-646, Section 216).

(2) Domestic Volunteers Services Act of 1973 (Public Law 93-113) as amended.

(3) Vista, University Year for Action.

(4) Payments derived from certain submarginal land of the United States which is held in trust for certain Indian Tribes (Public Law 94-114, Section 6).

(5) Payments from Crisis Intervention Program.

(6) CETA Youth Programs (Public Law 95-524) which include:

Youth Incentive Entitlement Pilot Project.

Youth Community Conservation and Improvement Project.

Youth Employment and Training Program.

(7) Indian Claims Commission Payments (Public Law 95-433).

(8) Job Training Partnership Act (Public Law 97-300) including salaries paid by employers to JTPA participants in an on-the-job training component.

(9) Income derived from the disposition of funds to the Grand River Band of Ottawa Indians (Public Law 94-540).

(10) Alaska Native Claims Settlement Act (Public Law 92-203).

(11) Low Income Home Energy Assistance Program.

(12) Financial assistance received from any program funded under Title IV of the Higher Education Act for students attending an institution of postsecondary education at least half-time which is used by the students for tuition and mandatory fees or as an allowance for books, supplies, transportation and miscellaneous personal expenses.

d. Income guidelines. Persons are financially eligible for this program when they are in one of the following categories:

(1) *Income maintenance status.* All members of the household are recipients of the family investment program, recipients of supplemental security income, or recipients of the food stamp program.

(2) *Income eligible status.* The gross income according to family size is no more than the following amounts:

Household Size	Yearly Income	Monthly Income	Weekly Income
1	$15,448	$1,288	$298
2	20,813	1,735	401
3	26,178	2,182	504
4	31,543	2,629	607
5	36,908	3,076	710
6	42,273	3,523	813
7	47,638	3,970	917
8	53,003	4,417	1,020
For each additional household member add:	$ 5,365	$ 448	$104

441—73.5(234) Notification of available food. The public shall be informed of the availability of food, the type of food available and the location and times of distribution by announcements through local media.

441—73.6(234) Household certification procedure. A responsible member of the household or designated proxy shall complete and sign a Declaratory Statement of Eligibility, FP-1102-0, prior to receiving food. The Declaratory Statement of Eligibility declares household residency, size, and income; that the household is not receiving food under this program as part of another household or at another distribution site; acknowledges an understanding of possible prosecution, under current law, for accepting food for which the household may not be eligible; agrees to cooperate with a quality control review; and indicates an understanding that the food received through this program is not to be sold or exchanged. The household member or proxy may be asked to show some official identification before receiving the food.

73.6(1) *Proxy designation.* When a member of the household cannot be present to complete the Declaratory Statement of Eligibility due to disability, employment, or lack of transportation, the member may authorize a proxy to act on behalf of the household by completing an application in advance and having a proxy pick up the food at the distribution site, or by sending a signed note of authorization with the person acting as a proxy.

73.6(2) Reserved.

441—73.7(234) Distribution to households. The amount and type of federal surplus food distributed to each needy household shall be based upon the amount and type of food timely available and the individual household size. The schedule of distribution shall also be based upon the amount and type of food timely available and upon the availability of distribution and storage resources. A household may request less than the amount of food it is entitled to receive.

441—73.61(234) Disaster feeding. Any donated food received in the institution food distribution program may be used for group disaster feeding purposes with approval from the food distribution unit.

441—73.62(234) Food losses. All food losses regardless of the dollar amount shall be reported to the food distribution unit by the entity (recipient institution, warehouse, or food processor) responsible for the food. The food distribution unit shall log in each loss by entity. Losses shall accumulate by entity from October 1 to September 30 of each year.

73.62(1) *Definition of lost foods.* Lost foods means those foods which, for any reason, 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 or eligible recipients for whom they were intended. 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, distributing above authorized rates, and in the case of charitable institutions, on the basis of a greater population than the number of needy persons served.

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.

73.62(2) *Determination of fault.* The food distribution unit shall investigate the food loss and determine who is at fault.

73.62(3) *Claim action.* If the entity is at fault a claim action shall be initiated if the value of the accumulated food loss exceeds $100 unless there is evidence of violation of a federal or state statute. A claim action must be initiated regardless of the value of the food losses if the food losses occur when in transit for delivery.

73.62(4) *Processing of claims.*

a. Up to three demand letters will be sent to the entity determined responsible for the loss.

b. Interest (late charge) shall be assessed against an entity beginning on the thirty-first day following the date of the first demand letter at the rate determined by the U.S. Treasury Department at the beginning of each fiscal quarter.

c. Failure to make restitution when requested is cause for cancellation of the agreement.

d. When an entity accumulates losses totaling $2,500 in a federal fiscal year, the bureau of food distribution shall refer the loss to the USDA Food and Nutrition Service regional office.

73.62(5) *Claim payment.*

a. The claim shall be paid to the food distribution unit.

b. Replacement-in-kind with generically like items in lieu of cash payment may be used for losses with the approval of the food distribution unit if the replacement-in-kind would not result in further losses and the inventory is not already in excess.

c. If replacement-in-kind is not practicable, similar replacement may be used in lieu of cash payment with the approval of the food distribution unit and the Food and Nutrition Service regional office. Similar replacement means replacement of lost foods with a like quantity of similar domestically produced foods from the same food group.

d. The loss of bonus items may not be paid with replacement-in-kind or similar replacement items. Bonus items are those so designated by USDA and offered by USDA to the states as a one-time offer.

73.62(6) *Administrative review of claim.* An entity may request an administrative review of its claim in writing within 20 days of receipt of its first demand letter. The procedures outlined in rule 441—73.54(234) shall be used.

These rules are intended to implement Iowa Code sections 234.6 and 234.12.

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CHAPTER 74

Transferred to Chapter 73 as rules 441—73.41 to 441—73.62, IAB 5/3/89

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 PA-1107, 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 12/1/197.

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 185 percent of the federal poverty level for pregnant women when establishing initial eligibility under these provisions and for infants (under one year of age) when establishing initial and ongoing eligibility. 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 in accordance with the provisions of rule 441—75.57(249A).

In determining eligibility for pregnant women and infants, after the aforementioned disregards and deductions have been applied, an additional disregard equal to 15 percent of the applicable federal poverty level shall be applied to the family's income.

(2) Moneys received as a nonrecurring 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 this subparagraph. Nonrecurring lump sum income shall be considered as income in the budget month and considered in the eligibility determination for the benefit month, 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. The lump sum shall be prorated and considered in the eligibility determination by dividing the nonrecurring lump sum plus other countable income received in the month the lump sum was received by the standard of need in effect for the household size in accordance with subrule 75.58(1). The resulting number of months shall be called the "proration period." Any income remaining after this calculation shall be applied as income to the first month following the proration period and disregarded as income thereafter.

The proration period shall be shortened in accordance with the provisions of subparagraph 75.57(9)*"c"*(2) unless otherwise specified.

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 chapter 141. 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 Release or Obtain 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, 83, and 86, 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.*

a. If 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 specified in 75.23(2), the institutionalized individual is ineligible for medical assistance 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 during the period beginning on the first day of the first month during or after which assets were transferred for less than fair market value and which does not occur in any other periods of ineligibility under this rule and equal to the number of months specified in 75.23(3).

b. If 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 specified in 75.23(2), the individual is ineligible for medical assistance for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services during the period beginning on the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this rule and equal to the number of months specified in 75.23(3).

75.23(2) *Look-back date.* 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 the date an institutionalized individual is both an institutionalized individual and has applied for medical assistance or the date the 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 75.23(2), divided by the statewide average private pay rate for nursing facility services at the time of application. The average statewide cost to a private pay resident shall be determined by the department and updated annually for nursing facilities. For the period from July 1, 2000, through June 30, 2001, this average statewide cost shall be $2,933 per month or $96.43 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 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 trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(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:

(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 food, clothing, shelter, medical care, or other necessities of life, such that the individual's health or life would be endangered.

(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 nursing facility services.

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.

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

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 633.707 to 633.711, the average statewide charges and Medicaid rates for the period from July 1, 2000, to June 30, 2001, shall be as follows:

(1) The average statewide charge to a private pay resident of a nursing facility is $2,758 per month.

(2) The average statewide charge to a private pay resident of a hospital-based skilled nursing facility is $9,836 per month.

(3) The average statewide charge to a private pay resident of a non-hospital-based skilled nursing facility is $4,523 per month.

(4) The average statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $8,510 per month.

(5) The average statewide charge to a resident of a mental health institute is $9,962 per month.

(6) The average statewide charge to a private pay resident of a psychiatric medical institution for children is $4,359 per month.

(7) The average statewide charge to a home- and community-based waiver applicant or recipient 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.

(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 for Census 2000 during the period of April 1, 2000, through January 31, 2001.

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 whose needs are excluded from the eligible group is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 50 percent work incentive deduction described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4), and 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 75.57(10). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

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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 in the Medicare program (Title XVIII of the Social Security Act).

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 which 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).

441—77.25(249A) Genetic consultation clinics. Rescinded IAB 6/28/00, effective 8/2/00.

441—77.26(249A) Nurse-midwives. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and if they possess evidence of certification as a nurse-midwife as set forth in board of nursing rules 655—Chapter 7. Advanced registered nurse practitioners in other states shall be eligible to participate if they are duly licensed in that state and they possess evidence of certification to practice as a nurse-midwife according to the standards imposed by that state.

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

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 department of education.

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 in 441—Chapter 24 and 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.

441—77.30(249A) HCBS ill and handicapped waiver service providers. The following HCBS ill and handicapped waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules, 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

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 meet one of the following conditions:

a. The provider shall have a contract with the Veterans Administration to provide adult day health care.

b. The provider shall meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

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 HCBS MR 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 (RCF/PMR) licensed 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, and 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 service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

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

441—77.31(249A) Nurse anesthetists. Nurse anesthetists are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and (1) they possess evidence of certification as a certified registered nurse anesthetist as set forth in board of nursing rules 655—Chapter 7 or (2) within the past 18 months, they have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists and are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing. Nurse anesthetists in other states shall be eligible to participate if they are duly licensed in that state and meet requirements (1) or (2) above. Nurse anesthetists who have been certified eligible to participate in Medicare will be considered as having met the above-stated guidelines.

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. The following HCBS elderly waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

77.33(1) *Adult day care providers.* Adult day care providers shall meet one of the following conditions:

a. Contract with the Veterans Administration to provide adult day health care.

b. Meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

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 which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

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 HCBS MR 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).

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, and 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. Area agencies on aging as designated in 321—4.4(231). Chore 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 chore services may also provide chore services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers contracting with the department of public health shall be considered to have met these standards.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers certified under the HCBS MR waiver.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 321—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 137B.

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 321—4.4(231). Home and vehicle modification 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 and vehicle modification services may also provide home and vehicle modification services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Home and vehicle modification providers certified under the HCBS MR waiver.

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 321—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.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

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. Licensed dietitians approved by an area agency on aging.

77.33(13) *Assistive devices providers.* The following providers may provide assistive devices:

a. Medicaid-eligible medical equipment and supply dealers.

b. Area agencies on aging as designated according to department of elder affairs rules 321—4.3(249D) and 321—4.4(249D).

c. Assistive devices providers with a contract with an area agency on aging or with a letter of approval from an area agency on aging stating the organization is qualified to provide assistive devices.

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 service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

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

441—77.34(249A) HCBS AIDS/HIV waiver service providers. The following HCBS AIDS/HIV waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

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 which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135) and 641—80.7(135), or which are certified as a home health agency under Medicare.

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 HCBS MR waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 1114 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).

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, and 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 137B.

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 321—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 meet one of the following conditions:

a. The provider shall have a contract with the Veterans Administration to provide adult day health care.

b. The provider shall meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

77.34(8) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

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

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Health Care Financing Administration 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) Family or pediatric nurse practitioner. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and they possess evidence of certification as a certified family nurse practitioner or certified pediatric nurse practitioner as set forth in board of nursing rules 655—Chapter 7. Advanced registered nurse practitioners in other states shall be eligible to participate if they are duly licensed in that state and are certified as a family nurse practitioner or a pediatric nurse practitioner. Family or pediatric nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met the above-stated guidelines.

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

441—77.37(249A) HCBS MR waiver service providers. Supported community living and supported employment providers shall be eligible to participate as approved HCBS MR service providers in the Medicaid program based on the outcome-based standards set forth below in subrules 77.37(1) and 77.37(2) evaluated according to subrules 77.37(10) to 77.37(12), the requirements of subrules 77.37(3) to 77.37(9), and the applicable subrules pertaining to the individual service. Respite providers shall meet the conditions set forth in subrules 77.37(1) and 77.37(15). Home and vehicle modification shall meet the conditions set forth in subrule 77.37(17). Personal emergency response system providers shall meet the conditions set forth in subrule 77.37(18). Nursing providers shall meet the conditions set forth in subrule 77.37(19). Home health aide providers shall meet the conditions set forth in subrule 77.37(20). Consumer-directed attendant care providers shall meet the conditions set forth in subrule 77.37(21). Interim medical monitoring and treatment providers shall meet the conditions set forth in subrule 77.37(22).

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS MR 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 demonstrates methods of evaluation.

(1) Past performance is reviewed.

(2) Current functioning is evaluated.

(3) Plans are made for the future based on the evaluation and review.

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) *Minimizing barriers to services.* Services shall be delivered in a manner which minimizes barriers to the receipt of services.

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' division of mental health and developmental disabilities quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. The provider shall request an application from CONSULTEC.

b. The provider shall submit an application to CONSULTEC using Form 470-2917, HCBS Application for Certification. The application shall be submitted to Provider Enrollment, CONSULTEC, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422.

c. The applicant shall submit the completed application to CONSULTEC at least 90 days before the planned service implementation date. CONSULTEC shall forward the application to the department for processing.

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.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

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 local county central point of coordination and other interested parties.

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 Council 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 which 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 consumer will be severely jeopardized if the circumstances are not immediately corrected. The situation shall be corrected by the provider within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services which were the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer 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 consumers 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, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS MR 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 Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, 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. Living units designed to serve more than three supported community living recipients shall be approved only as follows:

(1) Living units designed to serve four recipients shall be approved subject to all of the following conditions:

1. Only existing residential facility structures owned or operated by the provider as of November 4, 1994, shall be used.

2. The provider shall provide justification of the need for the service to be provided in a four-person living unit instead of a living unit for three persons or less.

3. The requirements of Iowa Code paragraph 135C.6(8)*"b"* shall be met.

(2) The department shall approve a total of 20 living units for five persons or fewer which are licensed as residential care facilities for persons with mental retardation. The residential care facility shall surrender the facility license and continue to operate under the medical assistance home- and community-based services waiver for persons with mental retardation. Applications from providers for conversion shall be submitted to the Division of Mental Health and Developmental Disabilities, Hoover State Office Building, Fifth Floor, Des Moines, Iowa 50319-0114.

1. There shall be four conversions in each of the department's five service regions. The department may reallocate any unused conversion authorization to another region.

2. Recommendations for conversions will be made to the department by an advisory committee set up for each of the five regions. For each region the members shall include all of the central point of coordination administrators, with an advisory representative from the department. Each region shall submit its recommendation for the allocation of its four facilities currently licensed as residential care facilities for persons with mental retardation that will convert to home- and community-based waiver services for persons with mental retardation.

3. Approval of providers shall be made by the department's mental health and developmental disabilities division. Approval of providers shall be based on the advisory committee's recommendation, the geographical distribution of providers, and the counties' written assurance that they will request sufficient slots for the consumers to be served and agree to provide necessary funding.

(3) Subject to federal approval, a residential program which serves not more than eight individuals and is licensed as an intermediate care facility for persons with mental retardation may surrender the facility license and continue to operate under the home- and community-based services waiver for persons with mental retardation if the department has approved the timelines submitted by the residential program pursuant to subparagraph 77.37(14)*"d"*(1).

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 (RCF/PMR) 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 health services accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

(7) Home care agencies that meet the home care standards and requirements set forth in department of public health rules 641—80.5(135) through 641—80.7(135).

(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).

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, and 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. Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:

(1) Consumer 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.

(5) Department of labor requirements.

b. 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.* A home and vehicle modification provider shall be an approved HCBS MR supported community living service provider and shall meet the following standards:

a. The provider shall obtain a binding contract with community business(es) to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, the company or individual's work to be performed, cost, time frame for work completion, employer's liability coverage, and workers' compensation coverage.

b. The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.41(4).

c. The business, or the business's parent company or corporation, shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

d. The business, or the business's parent company or corporation, shall be in compliance with all legislation relating to prohibition of discriminatory practices.

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.* The following nursing providers may provide HCBS MR nursing services:

a. Providers which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

b. Individuals who meet the standards and requirements set forth in nursing board rules 655—Chapter 3, work under the direct orders of the HCBS MR consumer's physician, and have an HCBS agreement with the department.

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 service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

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

441—77.38(249A) Rehabilitative treatment service providers. Rehabilitative treatment service providers are eligible to participate in the Medicaid program if they are certified to be providers pursuant to rules 441—185.9(234) to 441—185.11(234).

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

441—77.39(249A) HCBS brain injury waiver service providers. Adult day care, behavioral programming, case management, consumer-directed attendant care, family counseling and training, home and vehicle modification, interim medical monitoring and treatment, personal emergency response, prevocational service, respite, specialized medical equipment, supported community living, supported employment, and transportation providers shall be eligible to participate as approved brain injury waiver service providers in the Medicaid program based on the applicable subrules pertaining to the individual service and provided that they and each of their staff involved in direct consumer service have training regarding or experience with consumers who have a brain injury. 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 demonstrates methods of evaluation.

(1) Past performance is reviewed.

(2) Current functioning is evaluated.

(3) Plans are made for the future based on the evaluation and review.

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) *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.

77.39(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' division of mental health and developmental disabilities quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. The provider shall request an application from CONSULTEC.

b. The provider shall submit an application to CONSULTEC using Form 470-2917, HCBS Application for Certification. The application shall be submitted to Provider Enrollment, CONSULTEC, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422.

c. The applicant shall submit the completed application to CONSULTEC at least 90 days before the planned service implementation date. CONSULTEC shall forward the application to the department for processing.

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.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

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. 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 local county central point of coordination and other interested parties.

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 Council 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 which 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 consumer will be severely jeopardized if the circumstances are not immediately corrected. The situation shall be corrected by the provider within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services which were the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer 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 consumers 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, 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 not more than four supported community living consumers meeting criteria listed below:

(1) The department shall approve the four-person or less HCBS brain injury waiver living units on a statewide basis. Approval shall be according to the provider's ability to meet the criteria in rule 441—77.39(249A). New four-person structures not owned or operated as of November 9, 1994, shall not be approved. Use of existing residential facility structures owned or operated by the provider as of November 9, 1994, must be justified by the need for the service to be provided in a four-person living unit instead of a three- or less person living unit. The geographic location of the program must be such so as to avoid an overconcentration of programs in an area.

(2) Providers of service may seek approval to provide supported community living services to not more than four HCBS brain injury waiver consumers per living unit according to subrule 77.39(8) if all consumers residing in the living unit receive on-site staff supervision during the entire time period consumers are present in the living unit and if each consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

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 mental retardation waiver.

(2) Adult day health service providers accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

(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 (RCF/PMR) 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).

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, and 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. Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:

(1) Consumer 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.

(5) Both state and federal department of labor requirements.

b. The department shall certify only 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.* A home and vehicle modification provider shall be an approved HCBS brain injury waiver supported community living service provider and shall meet the following standards:

a. The provider shall obtain a binding contract with community businesses to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, cost, time frame for work completion, employer's liability coverage, and workers' compensation coverage.

b. The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.43(5).

c. The business, or the business's parent company or corporation, shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

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 321—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.

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 meet one of the following conditions.

a. The provider shall have a contract with the Veterans Administration to provide adult day health care.

b. The provider shall meet one of the following sets of standards individually or as an integral service provided by an organization:

(1) Standards of the Joint Commission on Accreditation of Health Care Organizations.

(2) Standards set forth in rule 441—171.5(234).

(3) Standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers 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. Providers 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. Providers 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.

d. Providers which are qualified brain injury professionals. A qualified brain injury professional shall be 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; 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.

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. 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.

A qualified brain injury professional is defined in paragraph 77.39(21)*"d."*

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 with the qualifications described in paragraph 77.39(21)*"d"* 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) Supported community living providers certified under rules 441—77.39(13).

77.39(24) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

441—77.40(249A) Lead inspection agency providers. Lead inspection agency providers are eligible to participate in the Medicaid program if they are certified pursuant to 641—subrule 70.5(4), department of public health.

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

441—77.41(249A) HCBS physical disability waiver service providers. Consumer-directed attendant care, home and vehicle modification, personal emergency response system, specialized medical equipment, and transportation service providers shall be eligible to participate as approved physical disability waiver service providers in the Medicaid program based on the applicable subrules pertaining to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's division of medical services 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.

c. The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties to be served by the provider.

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 consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating that they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.41(3) *Home and vehicle modification providers.* A home and vehicle modification provider shall be either:

a. An approved HCBS brain injury or mental retardation supported community living service provider that meets all the following standards:

(1) The provider shall obtain a binding contract with a community business to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, cost, time frame for work completion, employer's liability coverage, and workers' compensation coverage.

(2) The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.46(2).

(3) The business, or the business's parent company or corporation, shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

b. A community business that performs the work and meets all the following standards:

(1) The community business shall enter into binding contracts with consumers to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, cost, time frame for work completion, employer's liability coverage, and workers' compensation coverage.

(2) The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.46(2).

(3) The business, or the business's parent company or corporation, shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

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 321—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.

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

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ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid fiscal agent 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 recipient 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 recipient 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 recipient'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 recipient's residence when medically necessary.

Medicaid recipients 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 recipient.

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 recipient'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 recipient 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 recipient in response to treatment.
g. Medical supplies to be furnished.
h. Recipient's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The date of the signature shall be within the certification period.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the recipient 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 recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The recipient 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 recipient 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 recipient in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the recipient's institutionalization when the primary need of the recipient 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 recipient, 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 recipient's illness or injury.

(2) Contribute meaningfully to the treatment of the recipient'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 recipient's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the recipient 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 recipients 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.

Treatment plans for maternity patients and children shall identify the potential risk factors, the medical factor or symptom which verifies the child is at risk, the reason the recipient is unable to obtain care outside of the home, and the medically related task of the home health agency. If the home health agency is assisting the family to cope with socioeconomic and medical problems, the plan of care shall indicate the involvement of the department's county office and document that the department and the home health agency have agreed that services are in the best interest of the child and are needed to supplement the intervention of the department social worker.

The plan of treatment shall document along with the high-risk factors, the diagnosis, specific services and goals, and the medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

a. 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.

c. Nutrition services shall be provided by a licensed dietitian. Nutrition assessment and counseling 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 services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Psychosocial assessment and counseling 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 shall be provided by a registered nurse and 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 and referral to community resources as needed.

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

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure.

The covered services provided by an ambulatory surgical center shall be those services covered by the Medicare program and those services which can be safely performed in an outpatient setting as determined by the department upon advice from the Iowa Foundation for Medical Care. Covered surgical procedures shall be those medically necessary procedures that are eligible for payment and under the same circumstances as physicians' services specified in 78.1(249A) performed on an eligible recipient.

78.26(1) Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

78.26(2) Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

78.26(3) 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, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

441—78.27(249A) Genetic consultation clinics. Rescinded IAB 6/28/00, effective 8/2/00.

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows:

a. Prior approval is required for amphetamines and combinations of amphetamines with other therapeutic agents and amphetamine-like sympathomimetic compounds used for obesity control, including any combination of these compounds with other therapeutic agents. Payment for these medications will be provided when there is a diagnosis of narcolepsy, hyperkinesis in children, or senile depression and not for obesity control. (Cross-reference 78.1(2)*"a"*(3))

b. Prior approval is required for multiple vitamins, tonic preparations and combinations with minerals, hormones, stimulants, or other compounds which are available as separate entities for treatment of specific conditions. Payment for these vitamins, preparations, or compounds will be approved when there is a specifically diagnosed vitamin deficiency disease or for recipients aged 20 or under if there is a diagnosed disease which inhibits the nutrition absorption process secondary to the disease. (Prior approval is not required for products principally marketed as prenatal vitamin-mineral supplements.) (Cross-reference 78.1(2)*"a"*(3))

c. Enteral products and enteral pumps and supplies require prior approval. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's written order or prescription and documentation to establish the medical necessity for enteral products and enteral pumps and supplies which includes:

1. A statement of the recipient's total medical condition that includes a description of the recipient's metabolic or digestive disorder.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the recipient's nutritional status and indicate that the recipient's nutritional needs were not or could not be met by regular food in pureed form.

441—78.29(249A) Nurse-midwives. Payment will be made for services provided by nurse-midwives contingent upon the following criteria being met:

78.29(1) The services provided are within the scope of the practice of nurse midwifery, including advanced nursing and physician-delegated functions under a protocol with a collaborating physician.

78.29(2) The women served by a nurse-midwife must be examined by a physician on at least two occasions during the pregnancy: an initial screening review of the women to determine the appropriateness for nurse-midwife care and during the last month of the pregnancy. A joint determination must be made by the nurse-midwife and the physician that the women are obstetrically low-risk and eligible for care by a nurse-midwife.

Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's 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).)

78.29(3) The nurse-midwife shall provide for referral for the infant's neonatal examination.

78.29(4) The nurse-midwife shall have promptly available the necessary equipment and personnel to handle emergencies.

78.29(5) The services of the nurse-midwife are provided in birth centers, hospitals, or clinics.

78.29(6) The nurse-midwife providing services in other than a hospital shall negotiate a written agreement with one or more hospitals for the prompt transfer of patients requiring care. The patient record information shall be transmitted with the patient at the time of transfer.

78.29(7) The nurse-midwife shall maintain a current and complete medical record for each patient and shall have the record available for reference.

The record shall have at least the following: admitting diagnosis, physical examination, report of medical history, record of medical consultation where indicated, laboratory tests, X-rays, delivery reports, anesthesia record and discharge summary.

78.29(8) Payment will be made to nurse-midwives directly only if they are not auxiliary personnel as defined in subrule 78.1(13) or if they are not hospital employees.

78.29(9) Nurse-midwives who wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients 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 recipients. Nurse-midwives shall receive reimbursement for the administration of vaccines to Medicaid recipients.

This rule is intended to implement Iowa Code section 249A.4 and 1992 Iowa Acts, Second Extraordinary Session, chapter 1001, section 413.

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services. Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's 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).)

Birth centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid eligibles 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 eligibles. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid recipients.

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

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

(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 family or pediatric nurse practitioners employed by a hospital.* Hospitals may be reimbursed for services rendered by family or pediatric nurse practitioners who are employed by the hospital and providing services in a facility or other location that is owned by the hospital, but is not on or part of the hospital's licensed premises, if reimbursement is not otherwise available for the services rendered by these employed nurse practitioners. As a condition of reimbursement, employed family and pediatric nurse practitioners rendering these services must enroll with the Medicaid program, receive a provider number, and designate the employing hospital to receive payment. Claims for services shall be submitted by the employed family or pediatric nurse practitioner. Payment shall be at the same fee-schedule rates as those in effect for independently practicing family or pediatric nurse practitioners under 441—subrule 79.1(2).

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

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). These services shall be provided by personnel who meet standards as set forth in department of education rules 281—41.8(256B,34CFR300) to 281—41.10(256B) to the extent that their certification or license allows them to provide these services. Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 24.

78.33(1) Payment will be approved for case management services to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—22.1(225C). Persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

b. Recipients under 18 years of age with a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—22.1(225C) and with residence in a child welfare decategorization county, under the conditions stated in subrule 78.33(2).

c. Recipients under 18 years of age receiving HCBS MR services.

78.33(2) Payment for services to recipients under age 18 residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. Meal preparation planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

e. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

i. If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those set forth in subrule 78.41(4), paragraphs *"a"* to *"d."*

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 Case Management Program for the Frail Elderly (CMPFE) interdisciplinary team. A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip or rate established by area agency on aging. When paying the rate established by an area agency on aging, the monthly payment shall not exceed $200 per month for wheelchair or other handicapped transportation, or $100 per month for nonhandicapped transportation.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour, or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units.

d. The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

i. If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

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

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

f. Provider budgets shall reflect all staff-to-consumer ratios. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. The necessary components of the system are:

(1) An in-home medical communications transceiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Vehicle and home modifications.* Covered vehicle and home modifications are those physical modifications to the consumer's home environment and vehicle which are necessary to provide for the health, welfare and safety of the consumer, and which enable the consumer to function with greater independence in the home or vehicle.

a. Services shall be included in the consumer's individual comprehensive plan or service plan and shall exceed the Medicaid state plan services.

b. These services may include the purchase, installation or modification of:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves and ovens, grab bars and handrails.

(2) Bathtubs and toilets to accommodate wheelchair transfer, shower and bathtub seats, grab bars, special handles and hoses for shower heads, water faucet controls, wheelchair-accessible showers and sink areas, and turnaround space adaptations.

(3) Entrance ramps and rails, lifts for porches or stairs, door, hall, and window widening, fire safety alarm equipment specific for hearing and visually disabled, voice-activated, light-activated, motion-activated, and electronic devices, air filtering, and heating and cooling adaptations.

(4) Vehicle floor or wall bracing, lifts, and driver-specific adaptations.

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. Home and vehicle modifications shall be provided by community businesses. Services shall be performed following department approval of a binding contract between the supported community living service provider and the community business.

f. Service payment shall be made to the supported community living service provider to forward to the applicable community business following completion of the approved modifications.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the consumer which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS MR supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the consumer's individual comprehensive plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are those services of instruction, supervision and assistance associated with attaining and maintaining paid employment.

a. The components of the service are instructional activities to obtain a job, initial instructional activities on the job, enclave settings as defined in paragraph *"i,"* and follow-along. The service consists of:

(1) Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(2) Employment-related adaptations required to assist the consumer within the employment setting.

(3) Transportation, when provided between the consumer's place of residence and the supported employment site or between sites (in situations where the consumer receives the services in more than one place). Ordinary forms of community transportation (car pools, coworkers, self or public transportation) should be attempted before the service provider provides transportation.

b. Individualized or dispersed placements are the preferred service model.

c. The majority of coworkers within the employment site which has more than two employees shall be persons without disabilities. Daily contact shall be provided in the immediate worksite with other employees or the general public who do not have disabilities.

d. The individual and dispersed placement services shall provide individualized and indefinite follow-along support contacts at regular intervals with the consumer to promote successful job retention. A minimum of two contacts per month is required. As appropriate, contact at regular intervals shall be made with the employer and significant others. Contacts shall be documented.

e. Documentation shall be maintained in the file of each supported employment consumer that this service is not available under a program funded under the Rehabilitation Act of 1973 or P. L. 94-142.

f. Services shall be identified in the consumer's individual comprehensive plan.

g. Instructional activities to obtain a job. Reimbursement is available for instructional activities provided to the consumer and supported employment development activities associated with obtaining supported employment for the consumer.

(1) A unit is one day.

(2) A maximum of five units per week are available for a maximum of 16 weeks (80 units).

h. Initial instructional activities on job. Reimbursement is available for instructional activities associated with initial job training needs for consumers within individual, dispersed supported employment settings.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

i. Enclave settings. Reimbursement is available for activities associated with sustaining consumers within an enclave supported employment setting of two to eight persons with disabilities.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

j. Follow-along. Reimbursement is available for maintenance and follow-along activities which include individualized ongoing support activities required to sustain the consumer in the supported employment setting.

(1) A unit is one calendar month.

(2) A maximum of 12 units are available per state fiscal year.

k. Changes in the consumer's supported employment service or support needs shall be reflected in the individual comprehensive plan. Changes in the supported employment service model will result in changes in reimbursement on a quarterly basis.

l. Supported employment services shall not be simultaneously reimbursed with other supported employment, work activity, or sheltered work services, or with Medicaid or HCBS MR respite, nursing or home health aide services.

m. Rescinded IAB 3/2/94, effective 3/1/94.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

i. If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

441—78.42(249A) Rehabilitative treatment services. Payment will be made for rehabilitative treatment services as described in 441—Chapter 185, Divisions II to V, when the rehabilitative treatment services have been authorized by the review organization under the provisions set forth in rule 441—185.4(234) and the services are provided by providers certified as described in rules 441—185.10(234) and 441—185.11(234).

These rules are intended to implement Iowa Code section 249A.4.

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the participant's individual comprehensive plan (ICP). All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the ICP. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's individual comprehensive plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means activities provided, using an interdisciplinary process, to persons with a brain injury to ensure that the consumer has received a comprehensive evaluation and diagnosis, to give assistance to the consumer in obtaining appropriate services and living arrangements, to coordinate the delivery of services, and to provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

The service is to 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 which are a typical part of life, and fully participate as members of the community. It is essential that the case manager 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. Those who are at the ICF/MR level of care where the county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

Case management services shall consist of the following components:

a. Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.

b. Assurance that an individual comprehensive plan (ICP) is developed which addresses the consumer's total needs for services and living arrangements.

c. Assistance to the consumer in obtaining the services and living arrangements identified in the ICP.

d. Living units shall be located throughout the community at scattered sites. Settings larger than four units require the majority of living units to be occupied by individuals who are not disabled.

e. Provider budgets shall reflect all staff-to-consumer ratios. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) *Supported employment services.* Supported employment services are those services of instruction, supervision and assistance associated with attaining and maintaining paid employment.

a. The components of the service are instructional activities to obtain a job, initial instructional activities on the job, enclave settings as defined in paragraph 78.43(4)*"i,"* and follow-along. The service consists of:

(1) Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(2) Employment-related adaptations required to assist the consumer within the employment setting.

(3) Transportation, when provided between the consumer's place of residence and the supported employment site or between sites (in situations where the consumer receives the services in more than one place). Ordinary forms of community transportation (carpools, coworkers, self or public transportation) should be attempted before the service provider provides transportation.

b. Individualized or dispersed placements are the preferred service model.

c. The majority of coworkers within the employment site which has more than two employees shall be persons without disabilities. Daily contact shall be provided in the immediate work site with other employees or the general public who do not have disabilities.

d. The individual and dispersed placement services shall provide individualized and indefinite follow-along support contacts at regular intervals with the consumer to promote successful job retention. A minimum of two contacts per month is required. As appropriate, contact at regular intervals shall be made with the employer and significant others. Contacts shall be documented.

e. Documentation shall be maintained in the file of each supported employment consumer that this service is not available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142.

f. Services shall be identified in the consumer's individual comprehensive plan.

g. Reimbursement is available for instructional activities provided to the consumer and supported employment development activities associated with obtaining supported employment for the consumer.

(1) A unit is one day.

(2) A maximum of five units per week are available.

h. Reimbursement is available for instructional activities associated with initial job training needs for consumers within individual, dispersed supported employment settings.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week for 16 weeks (640 units).

i. Reimbursement is available for activities associated with sustaining consumers within an enclave supported employment setting of two to eight persons with disabilities.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

j. Reimbursement is available for maintenance and follow-along activities which include individualized ongoing support activities required to sustain the consumer in the supported employment setting.

(1) A unit is one calendar month.

(2) A maximum of 12 units are available per state fiscal year.

k. Changes in the consumer's supported employment service or support needs shall be reflected in the individual comprehensive plan. Changes in the supported employment service shall result in changes in reimbursement on a quarterly basis.

l. Supported employment services shall not be simultaneously reimbursed with other supported employment, work activity, or sheltered work services, or with Medicaid or HCBS brain injury waiver respite or personal assistance services.

m. Consumers residing in residential care facilities may receive supported employment services.

78.43(5) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home environment and vehicle which are necessary to provide for the health, welfare and safety of the consumer, and which enable the consumer to function with greater independence in the home or vehicle.

a. Services shall be included in the consumer's individual comprehensive plan or service plan and shall exceed the regular Medicaid services.

b. These services may include the purchase, installation, or modification of:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves and ovens, grab bars and handrails.

(2) Bathtubs and toilets to accommodate wheelchair transfer, shower and bathtub seats, grab bars, special handles and hoses for shower heads, water faucet controls, wheelchair-accessible showers and sink areas, and turnaround space adaptations.

(3) Entrance ramps and rails; lifts for porches or stairs; door, hall and window widening; motion-activated, and electronic devices; air filtering, and heating and cooling adaptations.

(4) Vehicle floor or wall bracing, lifts, and driver-specific adaptations.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be in accordance with applicable federal, state, and local building and vehicle codes.

e. Home and vehicle modifications shall be provided by community businesses. Services shall be performed following department approval of a contract between the supported community living provider and the community business.

f. Service payment shall be made to the supported community living service provider to forward to the applicable community business following completion of the approved modifications.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, to and from work or day programs, and to reduce social isolation. A unit of service is either per mile or per trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6000 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

i. If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Teleconsultive services.

78.45(1) *Covered services.* Payment for consultations on covered services done through the electronic transfer of medical information by interactive audiovisuals is available pursuant to Medicare-funded telemedicine waiver program guidelines to those Medicaid providers participating in a federally funded telemedicine waiver program who have entered into a billing instruction and data collection agreement with the department.

78.45(2) *Expenses and associated costs.* Payment for telecommunication expenses and associated costs for teleconsultive services covered under subrule 78.45(1) is available to medical institutions participating in Medicaid and in a federally funded telemedicine waiver program who have entered into a billing instruction and data collection agreement with the department.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

a. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to, or return from, a place of employment but not assistance to the consumer while the consumer is on the job site.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

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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 intermediate care 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 recipient.

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).

Copies of fee schedules in effect for the providers covered by fee schedules can be obtained by contacting the department's fiscal agent at the following address: Consultec, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422.

*d. * Monthly fee for service.* Providers are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in a case management program for any portion of the month 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 services provision.

*Effective 1/1/89, IAB 12/14/88

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/00 plus 0.7%. Air ambulance: A base rate of $209.54 plus $7.85 per mile for each mile the patient is carried.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Rate determined by Medicare
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Audiologists	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Birth centers	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Case management providers	Retrospective cost-related	Retrospective rate
Certified registered nurse anesthetists	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Chiropractors	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Clinics	Fee schedule	Maximum physician reimbursement rate
Community mental health centers	Fee schedule	Reimbursement rate for center in effect 6/30/00 plus 17.33%
Dentists	Fee schedule	75% of usual and customary rate

Provider category	Basis of reimbursement	Upper limit
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/00 plus 0.7%
Family planning clinics	Fee schedule	Fees in effect 6/30/00 plus 0.7%
Family or pediatric nurse practitioner	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Federally qualified health centers (FQHC)	Retrospective cost-related	1. Reasonable cost as determined by Medicare cost reimbursement principles 2. 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" above
HCBS AIDS/HIV waiver service providers, including:		
1. Counseling		
Individual:	Fee schedule	$10.07 per unit
Group:	Fee schedule	$40.26 per hour
2. Home health aide	Retrospective cost-related	Maximum Medicare rate
3. Homemaker	Fee schedule	$18.49 per hour
4. Nursing care	Agency's financial and statistical cost report and Medicare percentage rate per visit	Cannot exceed $74.77 per visit

Provider category	Basis of reimbursement	Upper limit
5. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectivly limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care

Provider category	Basis of reimbursement	Upper limit
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
6. Home-delivered meal providers	Fee schedule	$7.19 per meal. Maximum of 14 meals per week
7. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract.
8. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
HCBS brain injury waiver service providers, including:		
1. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$32.64 per hour, $73.61 per day
2. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
3. Personal emergency response system	Fee schedule	Initial one-time fee of $46.22. Ongoing monthly fee of $35.95.
4. Case management	Fee schedule	$575.49 per month
5. Supported employment:		
a. Instructional activities to obtain a job	Fee schedule	$34.70 per day
b. Initial instructional activities on the job	Retrospectively limited prospective rates. See 79.1(15)	$15.77 per hour
c. Enclave	Retrospectively limited prospective rates. See 79.1(15)	$5.78 per hour
d. Follow-along	Fee schedule. See 79.1(15)	$262.91 per month
6. Transportation	Fee schedule	State per mile rate
7. Adult day care	Fee schedule	$20.54 per half day, $41.09 per full day, or $61.63 per extended day
8. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
9. Home and vehicle modification	Fee schedule	$500 per month, not to exceed $6,000 per year
10. Specialized medical equipment	Fee schedule	$500 per month, not to exceed $6,000 per year
11. Behavioral programming	Fee schedule	$10.07 per 15 minutes
12. Family counseling and training	Fee schedule	$40.26 per hour
13. Prevocational services	Fee schedule. See 79.1(17)	$34.94 per day

Provider category	Basis of reimbursement	Upper limit
14. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour
HCBS elderly waiver service providers, including:		
1. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract.
2. Emergency response system	Fee schedule	Initial one-time fee $46.22. Ongoing monthly fee $35.95.
3. Home health aides	Retrospective cost-related	Maximum Medicare rate
4. Homemakers	Fee schedule	Maximum of $18.49 per hour
5. Nursing care	Fee schedule as determined by Medicare	$74.77 per visit
6. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
7. Chore providers	Fee schedule	$7.19 per half hour
8. Home-delivered meal providers	Fee schedule	$7.19 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification providers	Fee schedule	$1000 lifetime maximum
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year
11. Transportation providers	Fee schedule	State per mile rate for regional transit providers or rate established by area agency on aging.
12. Nutritional counseling	Fee schedule	$7.70 per quarter hour
13. Assistive devices	Fee schedule	$102.71 per unit
14. Senior companion	Fee schedule	$6.16 per hour
15. Consumer-directed attendant care:		
Agency provider other than an assisted living program	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Assisted living provider	Fee agreed upon by consumer and provider	$1,052 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $34.60 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
HCBS ill and handicapped waiver service providers, including:		
1. Homemakers	Fee schedule	Maximum of $18.49 per hour
2. Home health aides	Retrospective cost-related	Maximum Medicare rate
3. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract
4. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services

Provider category	Basis of reimbursement	Upper limit
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
5. Nursing care	Agency's financial and statistical cost report and Medicare percentage rate per visit	Cannot exceed $74.77 per visit
6. Counseling		
Individual:	Fee schedule	$10.07 per unit
Group:	Fee schedule	$40.26 per hour
7. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
8. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour

Provider category	Basis of reimbursement	Upper limit
HCBS MR waiver service providers, including:		
1. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$32.64 per hour, not to exceed a total per month of $73.61 times the number of days in the month. $73.61 per day. Variations to the upper limit may be granted by the division of medical services when cost-effective and in accordance with the service plan as long as the statewide average remains at or below $73.61 per day.
2. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Group respite	Retrospectively limited propsective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
3. Supported employment:		
a. Instructional activities to obtain a job	Fee schedule	$34.70 per day. Maximum of 80 units, 5 per week, limit 16 weeks
b. Initial instructional activities on the job	Retrospectively limited prospective rates. See 79.1(15)	$15.77 per hour. Maximum of 40 units per week
c. Enclave	Retrospectively limited prospective rates. See 79.1(15)	$5.78 per hour. Maximum of 40 units per week
d. Follow-along	Fee schedule. See 79.1(15)	$262.91 per month. Maximum of 12 units per fiscal year or $8.62 per day for a partial month.

Provider category	Basis of reimbursement	Upper limit
4. Nursing	Fee schedule as determined by Medicare	Maximum Medicare rate converted to an hourly rate
5. Home health aides	Retrospective cost-related	Maximum Medicare rate converted to an hourly rate
6. Personal emergency response system	Fee schedule	Initial one-time fee of $38.42 Ongoing monthly fee of $26.19
7. Home and vehicle modifications	Contractual rate. See 79.1(15)	Maximum amount of $5,000 per consumer lifetime
8. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
9. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed the maximum daily per diem for ICF/MR level of care
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed the maximum daily per diem for ICF/MR level of care
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour not to exceed the maximum daily per diem for ICF/MR level of care
HCBS physical disability waiver service providers, including:		
1. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
2. Home and vehicle modification providers	Fee schedule	$500 per month, not to exceed $6000 per year

Provider category	Basis of reimbursement	Upper limit
3. Personal emergency response system	Fee schedule	Initial one-time fee of $46.22. Ongoing monthly fee of $35.95.
4. Specialized medical equipment	Fee schedule	$500 per month, not to exceed $6000 per year
5. Transportation	Fee schedule	State per mile rate for regional transit providers, or rate established by area agency on aging. Reimbursement shall be at the lowest cost service rate consistent with the consumer's needs.
Hearing aid dealers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/00 plus 0.7%
Home health agencies (Encounter services-intermittent services)	Retrospective cost-related	Maximum Medicare rate
(Private duty nursing or personal care and VFC vaccine administration for persons aged 20 and under)	Interim fee schedule with retrospective cost settling based on Medicare methodology	Retrospective cost settling according to Medicare methodology
Hospices	Fee schedule as determined by Medicare	Medicare cap (See 79.1(14)*"d"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/00 increased by 3%
Hospitals (Outpatient)	Prospective reimbursement for providers listed at 441—paragraphs 78.31(1)*"a"* to *"f."* See 79.1(16)	Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 6/30/00 increased by 3%
	Fee schedule for providers listed at 441—paragraphs 78.31(1)*"g"* to *"n."* See 79.1(16)	Rates in effect on 6/30/00 increased by 3%
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from 12/31/99 cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
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 6/30/00 plus 0.7%
Nurse-midwives	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A)	Seventieth percentile of facility costs as calculated from all 6/30/00 cost reports
2. Skilled nursing care provided in: Hospital-based facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $346.20 per day for hospital-based skilled facilities

Provider category	Basis of reimbursement	Upper limit
Freestanding facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $163.41 per day for freestanding skilled facilities
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Reimbursement rate for provider in effect 6/30/99 plus 2%
Orthopedic shoe dealers	Fee schedule	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Physical therapists	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)	Fee schedule in effect 6/30/99 plus 2%
Podiatrists	Fee schedule	Fee schedule in effect 6/30/99 plus 2%
Prescribed drugs	See 79.1(8)	$4.13 or $6.42 dispensing fee (See 79.1(8)*"a"* and *"e"*)

Provider category	Basis of reimbursement	Upper limit
Psychiatric medical institutions for children (Inpatient)	Prospective reimbursement	Reimbursement rate for provider based on per diem rates for actual costs on 6/30/00, not to exceed a maximum of $147.20 per day
(Outpatient day treatment)	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Psychologists	Fee schedule	Reimbursement rate for provider in effect 6/30/99 plus 2%
Rehabilitation agencies	Retrospective cost-related	Reimbursement rate for agency in effect 6/30/00 plus 0.7%
Rehabilitative treatment services	Reasonable and necessary costs per unit of service based on data included on the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049. See 441—185.101(234) to 441—185.107(234). A provider who is an individual may choose between the fee schedule in effect November 1, 1993 (See 441—subrule 185.103(7)) and reasonable and necessary costs.	No cap
Rural health clinics (RHC)	Retrospective cost-related	1. Reasonable cost as determined by Medicare cost reimbursement principles 2. 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" above
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/00 plus 0.7%
State-operated institutions	Retrospective cost-related	

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule which is determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician are reimbursed on the basis of a fee schedule (see subrule 79.1(1)*"c"*). This payment is made directly to the physician.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" shall mean the hospital's cost report with fiscal-year-end on or after January 1, 1998, and prior to January 1, 1999, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting regulations for cost reporting periods ending on or after January 1, 1998, and prior to January 1, 1999.

"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 add-on payments for inflation, capital costs, direct medical education costs, and costs associated with treating a disproportionate share of poor patients and indirect medical education are added to form a final payment rate.

"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.

"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.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average.

"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.

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

(5) Allocation for disproportionate share. To determine the total amount of funding that shall be allocated to the graduate medical education and disproportionate share fund for disproportionate share payments, the department shall:

1. Sum all routine disproportionate share payments using paid claims to qualifying providers on or after July 1, 1998, and through June 30, 1999.

2. Sum all routine disproportionate share payments from claims made to qualifying providers when those claims have been used as a basis for the calculation of capitation rates and reimbursement with either an HMO or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for routine disproportionate share. The disproportionate share PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for routine disproportionate share (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for disproportionate share Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated updates. The total amount of disproportionate share reimbursement cannot exceed the cap that was implemented under Public Law 102-234.

(6) Distribution of disproportionate share fund. Distribution of the fund for disproportionate share shall be on a monthly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of direct medical education reimbursement (based upon paid claims to qualifying hospitals) and dividing the total amount of money allocated to the graduate medical education and disproportionate share fund for disproportionate share by each respective hospital's percentage.

If a hospital fails to qualify for reimbursement for disproportionate share under Iowa Medicaid regulations, the amount of money that would otherwise be allocated for that hospital shall be removed from the total fund.

z. *Adjustments to the graduate medical education and disproportionate share fund for changes in utilization.* Money shall be added to or subtracted from the graduate medical education and disproportionate share fund when the average monthly Medicaid population deviates from the previous year's averages by greater than 5 percent. The average annual population (expressed in a monthly total) shall be determined on June 30 for both the previous and current years by adding the total enrolled population for all respective months from both years' B-1 MARS report and dividing each year's totals by 12. If the average monthly number of enrolled persons for the current year is found to vary more than 5 percent from the previous year, a per member per month (PMPM) amount shall be calculated for each component (using the average number of eligibles for the previous year calculated above) and an annualized PMPM adjustment shall be made for each eligible person that is beyond the 5 percent variance.

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 Health Care Financing Administration (HCFA). 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 HCFA to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.* 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.

79.1(8) *Prescribed drugs.* The amount of payment shall be based on several factors in accordance with 42 CFR 447.331—333 as amended to October 28, 1987:

a. *"Estimated acquisition cost (EAC)"* is defined as the average wholesale price as published by First Data Bank less 10 percent.

"Maximum allowable cost (MAC)" is defined as the upper limit for multiple source drugs established in accordance with the methodology of the Health Care Financing Administration (HCFA) as described in 42 CFR 447.332(a)(i) and (ii).

The basis of payment for prescribed drugs for which the MAC has been established shall be the lesser of the MAC plus a professional dispensing fee of $4.13 or the pharmacist's usual and customary charge to the general public.

The basis of payment for drugs for which the MAC has not been established shall be the lesser of the EAC plus a professional dispensing fee of $6.42 or the pharmacist's usual and customary charge to the general public.

If a physician certifies in the physician's handwriting that, in the physician's medical judgment, a specific brand is medically necessary for a particular recipient, the MAC does not apply and the payment equals the average wholesale price of the brand name product less 10 percent. If a physician does not so certify, and a lower cost equivalent product is not substituted by the pharmacist, the payment for the product equals the established MAC.

Equivalent products shall be defined as those products which meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

b. The determination of the unit cost component of the drug shall be based on the package size of drugs most frequently purchased by providers.

c. No payment shall be made for sales tax.

d. All hospitals which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients 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 recipients. Hospitals receive reimbursement for the administration of vaccines to Medicaid recipients through the DRG reimbursement for inpatients and APG reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that a maximum allowable reimbursable cost for these drugs shall be established by the department at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

79.1(9) *Nursing facility reimbursement for skilled nursing care.* Reimbursement shall be prospective based on a per diem rate calculated for each facility by establishing a base year per diem to which an annual index is applied.

a. The base year per diem rate shall be the Medicaid cost per diem as determined using the facility's 1998 fiscal year-end Medicare cost report. The base per diem rate for facilities enrolled since 1998 will be determined using the facility's first finalized Medicare cost report. Determination of allowable costs for the base year will be made using Medicare methods in place on December 31, 1998. For facilities that have elected to receive the low Medicare volume prospective payment rate for 1998, the Medicare 1998 prospective payment rate plus ancillary costs attributable to skilled patient days and not payable by Medicare shall be used to determine the facility's Medicaid costs per patient day.

A new skilled facility shall be reimbursed at an interim rate determined by Medicare or, for facilities not participating in Medicare, at an interim rate determined using Medicare methodology. The initial interim rate shall be either the rate used by Medicare or a per diem (using Medicare methodology) developed using a projected cost statement from the facility. When the facility submits the first cost report to Medicare, the facility shall send a copy to the Medicaid fiscal agent. A new prospective rate shall be established based on this cost report effective the first day of the month in which the cost report is received. Interim and final rates may not exceed the maximum allowable costs established in paragraph *"d"* below unless the facility meets the requirements in paragraph *"e"* below.

b. In-state facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, have a failed attempt at weaning or are inappropriate for weaning, and have medical needs that require skilled care as determined by the Iowa Foundation for Medical Care shall receive reimbursement for the care of these patients equal to the maximum allowable cost for the type of facility (or, for disproportionate share facilities, the rate paid pursuant to paragraph *"e"*) plus a $100 per day incentive factor. Facilities may continue to receive reimbursement at these rates for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled criteria for those 30 days.

c. Nursing facilities providing skilled nursing care shall be classified as either hospital-based or free-standing (non-hospital-based). A hospital-based facility is under the management and administration of a hospital regardless of where the skilled beds are physically located.

d. Effective February 1, 2000, the maximum allowable cost for skilled care shall be $346.20 per day for hospital-based facilities and $163.41 per day for freestanding facilities.

e. Nursing facilities enrolled in the Iowa Medicaid program on May 31, 1993, providing skilled nursing care and serving a disproportionate share of Medicaid recipients shall be exempt from the payment ceiling. Nursing facilities which enroll in the Iowa Medicaid program on or after June 1, 1993, provide skilled care, and serve a disproportionate share of Medicaid recipients shall have an upper limit on their rate not to exceed 150 percent of the ceiling for the class of skilled nursing facility.

For nursing facilities providing skilled nursing care, a disproportionate share of Medicaid recipients shall exist when the total cost of skilled services rendered to Medicaid recipients in any one provider fiscal year is greater than or equal to 51 percent of the facility's total allowable cost for skilled services for the same fiscal year except as provided in subparagraphs (1) and (2). The department shall determine which providers qualify for this exemption.

(1) Nursing facilities enrolled in the Iowa Medicaid program on May 31, 1993, and meeting disproportionate share requirements on that date shall continue to be exempted from the payment ceiling if the total cost of services rendered to Medicaid recipients in any one provider fiscal year drops below 51 percent, but the total cost of services to Medicaid recipients is greater than 35 percent of the facility skilled nursing allowable cost for the same fiscal year.

For facilities meeting this condition, a 10 percent reduction in the Medicaid payment rate shall be made. For each percentage point in the facility's overall utilization rate (rounded to the nearest whole number) below 75 percent, a further 1 percent reduction shall be made in the Medicaid payment rate, in addition to any occupancy adjustment already made by the Medicare program.

(2) A facility meeting the conditions of subparagraph (1) as of July 1, 1996, or at a subsequent time, shall be subject to the following conditions and requirements:

- A census report shall be submitted to the department which verifies the Medicaid and overall occupancy of the facility for the entire year immediately preceding application by a facility to be reimbursed according to the conditions of this subrule.
- The initial rate for a facility approved for reimbursement under provisions of subparagraph (1) shall be the allowable Medicaid rate on the effective date less 10 percent and any further applicable percentage reduction.

Subsequent rate calculations shall be based on the annual cost report prepared by a facility subject to the limitations of this subparagraph and subject to an allowable rate of increase approved by the Iowa general assembly. These adjustments shall be effective July 1 of each year.

f. The current method for submitting billings and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

g. Out-of-state nursing facilities providing skilled nursing services shall be reimbursed at the same level as in their state of residence.

h. Payment for outpatient services by certified skilled nursing facilities shall be made at the Medicare rate of reimbursement.

i. Rates for skilled nursing facilities shall be rebased every three years.

j. Freestanding skilled facilities with a case-mix index above the statewide average for the previous reporting period shall receive a case-mix adjustment of $5.20 added to their daily rate for a six-month period. The case-mix index of each facility and the statewide average case-mix index are calculated by the United States Health Care Financing Administration from the minimum data set (MDS) report submitted by each facility pursuant to 441—subrule 81.13(9).

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.

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) *Reimbursement for HCBS MR and BI supported community living and supported employment and HCBS AIDS/HIV, BI, elderly, ill and handicapped, and MR respite when basis of reimbursement is retrospectively limited prospective rate.* This includes home health agencies providing group respite; nonfacility providers of specialized, basic individual, and group respite; camps; and home care agencies providing specialized, basic individual, and group respite.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form SS-1703-0, 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 department, division of medical services, 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 division of medical services 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 individual comprehensive 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 travel and transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year.

(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.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The annual adjustment shall be equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the division of medical services. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

(10) Early and periodic screening centers.
(11) Family or pediatric nurse practitioners.
(12) Family planning clinics.
(13) Federally qualified health centers. Federally qualified health centers shall also complete Form 470-2969, Federally Qualified Health Professionals Listing, and submit a copy of their federal grant.
(14) Rescinded IAB 6/28/00, effective 8/2/00.
(15) Hearing aid dealers.
(16) Independent laboratories.
(17) Maternal health centers. Maternal health centers shall also complete Form 470-2970, Group Practice Information.
(18) Nurse midwives.
(19) Orthopedic shoe dealers.
(20) Opticians.
(21) Optometrists.
(22) Physical therapists.
(23) Physicians.
(24) Podiatrists.
(25) Providers of prescribed drugs.
(26) Psychologists. Psychologists not on the National Register of Health Service Providers shall also complete Form 470-2968, Equivalency Form.
(27) Rural health clinics.

c. Hospices, health maintenance providers (HMOs), case management providers, and enhanced service providers shall submit Form 470-2976, Medicaid Provider Application for Hospices, HMOs, and Enhanced Service Providers.

d. Certified registered nurse anesthetists shall submit Form 470-2972, Medicaid Provider Application for Certified Registered Nurse Anesthetists.

e. All HCBS waiver providers shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date. Consultec shall forward the application to the department for processing.

f. and *g.* Rescinded IAB 12/3/97, effective 2/1/98.

h. Rehabilitative treatment service providers shall complete Form 470-3052, Rehabilitative Treatment and Support Services Contract.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the fiscal agent.

79.14(3) Notification. Providers shall be notified of the decision on their application by the fiscal agent within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the fiscal agent.

79.14(6) Providers approved for certification as a Medicaid provider shall complete Form 470-2965, Medicaid Provider Agreement.

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the department's fiscal agent 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 fiscal agent. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

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

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w. Ambulatory surgical centers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

x. Independently practicing psychologists shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

y. Rescinded IAB 6/28/00, effective 8/2/00.

z. Nurse-midwives shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

aa. Birth centers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

ab. Area education agencies shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

ac. Psychiatric medical institutions for children shall submit claims on Form UB-82-HCFA-1450.

ad. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care.

ae. All HCBS waiver service providers shall submit claims for a calendar month or less of service on Form 470-2486, Claim for Targeted Medical Care.

af. Certified registered nurse anesthetist providers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

ag. Hospice providers shall submit claims on Form UB-82-HCFA-1450.

ah. Rescinded IAB 6/4/97, effective 7/1/97.

ai. Rescinded IAB 6/4/97, effective 7/1/97.

aj. Federally qualified health centers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

ak. Independently practicing family or pediatric nurse practitioners shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

al. Rescinded IAB 6/4/97, effective 7/1/97.

am. Nursing facilities for persons with mental illness shall submit claims on Form UB-82-HCFA-1450.

an. Rehabilitative treatment providers shall submit claims on Form AA-2241-0, Purchase of Service Provider Invoice.

ao. Lead inspection agencies shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

80.2(3) Providers shall purchase or copy their supplies of forms HCFA-1450 and HCFA-1500 for use in billing.

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

441—80.3(249A) Amounts paid provider from other sources. 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 the carrier.

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim where the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the fiscal agent exceeds 365 days except that payment for claims submitted beyond the 365-day limit shall be considered if retroactive eligibility on newly approved cases is made which exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim.

EXCEPTION: Rehabilitative treatment service providers shall submit claims pursuant to rule 441—185.121(234).

80.4(2) *Claim adjustments.* A provider's request for an adjustment to a paid claim must be received by the fiscal agent within one year from the date the claim was paid in order to have the adjustment considered.

EXCEPTION: Rehabilitative treatment service providers shall have claim adjustments processed pursuant to rule 441—185.121(234).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* A medical identification card shall be issued to recipients for use in securing medical and health services available under the program. The cards are issued by the department on a monthly basis and are valid only for the month of issuance. Payment will be made for services provided an ineligible recipient when verification establishes that the recipient was issued a medical identification card for the month in which the service was provided.

80.5(2) *Third-party liability.* When a third-party liability for medical expenses exists, this resource shall be utilized before payment is made by the Medicaid program unless the pay and chase provisions defined in rule 441—75.25(249A) are applicable or when otherwise authorized by the department.

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

"Abuse" means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

"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 add-on" means additional Medicaid reimbursement based on the acuity and care need level of residents of a nursing facility.

"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.

"Denial of critical care" is a pattern of care in which the resident's basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident's serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Department" means the Iowa department of human services.

"Department's accounting firm" means the firm on contract with the department to calculate nursing facility rates and provide other accounting services as requested. The current accounting firm is Ryun, Givens, Wenthe & Company, 1601 48th Street, Suite 150, West Des Moines, Iowa 50266-6756.

"Department's fiscal agent" means the firm on contract with the department to enroll providers, process Medicaid claims, calculate skilled nursing facility rates, and perform other related functions. The current fiscal agent is Consultec, 7755 Office Park Drive, West Des Moines, Iowa 50266.

"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 skilled nursing facilities and swing-bed hospitals providing care unless stated otherwise.

"Facility-based" means a nurse aide training program which is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Informed consent" means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

"Iowa Foundation for Medical Care (IFMC)" is the peer review organization on contract with the department to provide level of care determinations. The address of IFMC is 6000 Westown Parkway, West Des Moines, Iowa 50266.

"Laboratory experience" means practicing care-giving skills prior to contact in the clinical setting.

"Minimum data set" or *"MDS"* refers to a federally required resident assessment tool. Information from the MDS is used by the federal Health Care Financing Administration to determine the facility's case-mix index for purposes of the case-mix add-on provided by 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.

"Non-facility-based" means a nurse aide training program which is offered by an organization which 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).

"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.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

81.6(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next 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.

81.6(13) *Facility-requested rate adjustment.* A facility may request a rate adjustment for a period of time no more than 18 months prior to the facility's rate effective date. The request for adjustment shall be made to the department's accounting firm.

81.6(14) *Payment to new facility.* A new facility 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 and the cost established. Subsequent reports shall be submitted from the beginning day of operation to the end of the fiscal year or six months' interim period, whichever comes first, and each six months thereafter.

81.6(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, not to exceed private pay charges. The facility may submit a report for the period from beginning of actual operation to the end of the fiscal year or may submit two cost reports within the fiscal year provided the second report covers a period of six months ending on the last day of the fiscal year. The facility shall notify the department's accounting firm of the date its fiscal year will end and of the reporting option selected.

81.6(16) *Establishment of ceiling and reimbursement rate.*

a. An inflation factor will be considered in determining the facility's prospective payment rate. The rate will be determined by using the change in the weighted average cost per diem of the compilation of various costs and statistical data as found in the two most recent reports of "unaudited compilation of various cost and statistical data." The percentage increase of this weighted average will be the basis for the next semiannual inflation factor. 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, on an annual basis.

b. An incentive factor shall be determined at the beginning of the state's fiscal year based upon the latest June 30 report of "unaudited compilation of various costs and statistical data." The incentive factor shall be equal to one-half the difference between the forty-sixth percentile of allowable costs and the seventy-fourth percentile of allowable costs. Notwithstanding the foregoing, under no circumstances shall the incentive factor be less than $1 per patient day or more than $1.75 per patient day.

c. For non-state-owned nursing facilities, the reimbursement rate shall be established by determining, on a per diem basis, the allowable cost plus the established inflation factor and the established incentive factor, subject to the maximum allowable cost ceiling, plus any applicable case-mix add-on.

d. For non-state-owned nursing facilities, an additional factor in determining the reimbursement rate shall be arrived at by dividing total reported patient expenses by total patient days during the reporting period. Patient days for purposes of the computation of patient care service expenses shall be inpatient days as determined by subrule 81.6(7). Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7) or 80 percent of the licensed capacity of the facility, whichever is greater.

e. Effective July 1, 2000, the basis for establishing the maximum reimbursement rate for non-state-owned nursing facilities shall be the seventieth percentile of participating facilities' per diem rates as calculated from the June 30, 2000, report of "unaudited compilation of various costs and statistical data."

f. Notwithstanding paragraph *"e,"* a semiannual case-mix factor shall be calculated and applied to the payment rates for certain facilities as follows:

(1) A case-mix index for each facility and the statewide average case-mix index are calculated by the United States Health Care Financing Administration from the minimum data set (MDS) report submitted by each facility pursuant to 441—subrule 81.13(9). A patient care cost per patient day is calculated by the department from the facility's most recent financial and statistical cost report by dividing the facility's patient care costs by patient days. This is compared to the statewide average for patient care costs computed as of every June 30 and December 31.

(2) Facilities with a case-mix index derived from MDS reports that exceeds the Iowa nursing facility average and with a patient care service cost that exceeds the average for all participating nursing facilities for the previous reporting period shall receive an addition of $5.20 to their payment rate for a six-month period.

(3) Facilities with a case-mix index that exceeds the Iowa nursing facility average and with a patient care service cost that is less than the average for all participating facilities for the previous reporting period shall receive an addition of $2.60 to their payment rate for a six-month period.

g. The per diem rate paid for skilled nursing care provided by a nursing facility certified under the Medicare program shall be established according to guidelines in 441—subrule 79.1(9).

h. Facilities, both hospital-based distinct units and freestanding, which have beds certified as Medicare-skilled beds may participate in both the skilled care program and the nursing facility program. These facilities shall submit Form 470-0030. The facility's costs shall be used to calculate the maximum nursing facility rate.

81.6(17) *Cost report documentation.* All nursing facilities 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 the 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.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* 249A.4, and 249A.16.

441—81.7(249A) Continued review. The Iowa Foundation for Medical Care shall review Medicaid recipients' need of continued care in nursing facilities, pursuant to the standards and subject to the reconsideration and appeals processes in subrule 81.3(1).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) *Retention.* Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.10(249A) Payment procedures.

81.10(1) *Method of payment.* 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—81.6(249A). The per diem rate shall be no greater than the maximum reasonable cost determined by the department.

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.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph *"b,"* subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph *"b,"* subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Preadmission screening for mentally ill individuals and individuals with mental retardation.

(1) A nursing facility shall not admit a new resident with mental illness or mental retardation unless the division of mental health, mental retardation, and developmental disabilities has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the Iowa Foundation for Medical Care prior to admission to determine whether the individual requires the level of services provided by the facility because of the physical and mental condition of the individual. If the individual requires nursing facility level of services, the individual shall receive specialized services for mental illness or mental retardation.

(2) Definition. For purposes of this rule:

1. An individual is considered to have "mental illness" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition as described in 42 CFR 435.1009.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) *Quality of care.* Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

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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 ILL AND HANDICAPPED WAIVER SERVICES

441—83.1(249A) Definitions.

"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 ill and handicapped 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.

"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 the mentally retarded 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.

"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.

441—83.2(249A) Eligibility. To be eligible for ill and handicapped 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 determined to be one of the following:

(1) Blind or disabled as determined by the receipt of social security disability benefits, or a disability determination made through the division of medical services. Disability determinations are made according to supplemental security income guidelines as per Title XVI of the Social Security Act.

(2) Aged 65 or over and residing in a county that is not served by the HCBS elderly waiver.

b. The person must be ineligible for medical assistance under other Medicaid programs or coverage groups with the exception of: the medically needy program, the in-home, health-related program when the person chooses the ill and handicapped waiver instead of the in-home, health-related program, the HCBS MR waiver when the person is a child under the age of 18 with mental retardation and meets the skilled nursing level of care, cases approved by the intradepartmental board for supplemental security income deeming determinations between 1982 and 1987, and children eligible for supplemental security income under Section 8010 of Public Law 101-239.

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 the mentally retarded. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual 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.

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 paragraphs 441—75.5(2)"*b*" and 441—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 a unit of adult day care, consumer-directed attendant care, counseling, home health aid, homemaker, nursing, or respite service per quarter.

83.2(2) *Need for services.*

a. The consumer shall have a service plan approved by the department which is developed by the county social worker as identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The social worker shall establish the interdisciplinary team for the 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 using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 is completed annually, or more frequently upon request or when there are changes in the client's condition.

(2) Service plans for persons aged 20 or under shall be developed or reviewed after the child's individual education plan and EPSDT plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Those service plans for persons aged 20 or under which include home health, homemaker, nursing, or respite services shall not be approved until a home health agency has made a request to cover the consumer's service needs through EPSDT.

b. The total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/MR
$2,480	$852	$3,019

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. 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.

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped 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 ill and handicapped waiver shall be subject to the number of clients to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of clients to be served are set forth at the time of each five-year renewal of the waiver or in amendments to the waiver. When the number of applicants exceeds the number of clients specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the division of medical services.

a. The county office shall contact the division of medical services for all applicants for the waiver to determine if a payment slot is available.

(1) For persons not currently receiving Medicaid, the county office shall contact the division of medical services by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current recipients, the county office shall contact the division of medical services by the end of the second working day after receipt of Form 470-0660, Home- and Community-Based Service Report, signed and dated by the recipient or a written request, signed and dated by the recipient.

b. By the end of the third day after the receipt of the completed Form PA-1107-0 or 470-0660, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is signed or date-stamped in the county office, whichever is later. Clients currently eligible for Medicaid shall be added to the waiting list on the basis of the date Form 470-0660, or a written request, is signed and dated or date-stamped in the county office, whichever is later. 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.

(2) Persons 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.

(3) Once a payment slot is assigned, written notice shall be given to the applicant, and the payment slot shall be held for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

83.3(3) *Approval of application.*

a. Applications for the HCBS ill and handicapped 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 assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(5) The application is pending because the assessment, Form SS-1644, or the case 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 SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

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. A client must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer 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 ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs *"a"* and *"c"* of this subrule 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 subrule 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 recipient has been in a medical institution for 30 consecutive days for other than respite care. Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client 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.

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.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped 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 for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped 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.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped 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 case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker services, home health services, adult day care services, respite care services, nursing services, counseling services, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.34(249A).

441—83.7(249A) Case plan. A case plan shall be prepared for ill and handicapped waiver clients in accordance with rule 441—130.7(234) except that case 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. In addition, the case plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

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 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped 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.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs *"a"* and *"b."*

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 Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. 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. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

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.

"Basic individual respsite" 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.

"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.

"Iowa Foundation for Medical Care" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Long-term care coordinating unit designated case management project for frail elderly" means the case management system which conducts interdisciplinary team meetings to develop and update care plans for persons aged 65 and older.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"Project coordinator" means the person designated by the administrative entity to oversee the long-term care coordinating unit's designated case management project for the frail elderly.

"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. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

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. Under the case management of a member of the long-term care coordinating unit designated case management project for the frail elderly.

83.22(2) *Need for services.*

a. Applicants for elderly waiver services shall have an assessment of the need for service and the availability and appropriateness of service. The tool used to complete the assessment shall be the assessment tool designated by the long-term care coordinating unit established at Iowa Code section 231.58. The assessment shall be completed by the designated case management project for the frail elderly in the community or the local service worker. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed assessment tool and supporting documentation as needed.

b. The total monthly cost of the elderly waiver services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

Skilled level of care	Nursing level of care
$2,480	$1,052

83.22(3) *Providers—standards.* Participants in the waiver shall be case managed by providers who meet all the following standards:

a. Be a member of the long-term care coordinating unit designated case management project for the frail elderly.

b. Have a bachelor's degree in a human services field or be currently licensed as a registered nurse. Up to two years, relevant experience may be substituted for two years of the educational requirement.

c. Have formal training in completion of the assessment tool.

d. Receive formal case management training as specified by the long-term care coordinating unit.

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.

441—83.31(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

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."

"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.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Iowa Foundation for Medical Care" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"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 resonsibility 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. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care. 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, ADC, or ADC-related coverage groups; medically needy at hospital level of care; eligible under 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.

83.42(2) *Need for services.*

a. The county social 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 Home- and Community-Based Services Assessment or Reassessment, Form SS-1644. Form SS-1644 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 $1650.

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 or pended although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(3) The application is pending because the assessment, Form SS-1644, or the case 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 SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

441—83.50(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS MR 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 mental retardation 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.

"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 mental retardation 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.

"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.

"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.

"Individual comprehensive plan (ICP)" (also known as individual program 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 involves more than one agency.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written goal-oriented plan of services developed for a consumer by the consumer and the provider agency.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each individual 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 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.

"Mental retardation" means a diagnosis of mental retardation under this division which shall be made only when the onset of the person's condition was prior to 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, published by the American Psychiatric Association.

"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 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. 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.

"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 licened 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.

441—83.61(249A) Eligibility. To be eligible for HCBS MR 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 primary diagnosis of mental retardation which shall be updated based on the following time lines:

Age	Initial application to HCBS MR waiver program	Recertification for persons with an IQ range of 54 or below, moderate range of MR or below	Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or mental disability equivalent to mental retardation	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every six years and when a significant change occurs	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or mental disability equivalent to mental retardation every three years and when a significant change occurs
18 through 21 years	• Psychological documentation substantiating diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation within three years prior to age 18, or • Diagnosis of mental retardation or mental disability equivalent to mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to 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 or a diagnosis of mental disability equivalent to mental retardation, if the last testing date was (1) more than five years ago for consumers with an IQ range of 55 or above or with a diagnosis of mild mental retardation, or (2) more than ten years ago for consumers with an IQ range of 54 or below or with a diagnosis of moderate MR or below	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five 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/MR. The Iowa Foundation for Medical Care 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) Persons shall have their names placed on the HCBS MR waiver referral list with the division of medical services, or

(2) Currently reside in a residential care facility for the mentally retarded or foster care group home for the mentally retarded, or

(3) Currently reside in an ICF/MR or nursing facility.

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, an adult must receive one unit of either consumer-directed attendant care, supported community living, respite, or supported employment service per calendar quarter. Children shall, at a minimum, receive one unit of either consumer-directed attendant care, respite service or supported community living service per calendar quarter under this program.

f. Have an individual comprehensive plan completed annually.

g. For supported employment services:

(1) Be at least age 18.

(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. Have an individual comprehensive plan or service plan approved by the department.

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.

83.61(2) *Need for services.*

a. Consumers currently receiving Medicaid case management or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

b. Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.

c. Persons 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 the Functional Assessment Tool, Form 470-3073, 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 470-3073 or other circumstances beyond the worker's control.

g. At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR 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. 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 Functional Assessment Tool, Form 470-3073.

(2) Service plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Service plans or ICPs for consumers 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 EPSDT and receives a determination of whether EPSDT is appropriate.

(4) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the division of medical services, designee or the county board of supervisors' designee. The service worker, department QMRP, 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 division of medical services' designee or the county board of supervisors' 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 MR program limit.* The number of persons served shall be subject to a limit based on the number of payment slots set forth in the HCBS MR waiver amendment. The department shall make a request to the Health Care Financing Administration (HCFA) to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to HCFA for changes to the program limit to be effective January 1 if requested by a county during the month of September.

a. The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement.

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.*

a. The county department office shall contact the division of medical services for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, or after disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

(3) A payment slot is assigned to the applicant upon confirmation of an available slot.

(4) Once assigned, written notice shall be given to the applicant, and the payment slot shall be held for the applicant for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the date on the county department's written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS MR program services as documented by the date of the consumer's signature on Form SS-1645-0. 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.

(2) Persons who do not fall within the available slots shall have their application 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. The county central point of coordination administrator for adults and the division of medical services for children and adults with state case status shall contact the county department when a slot becomes available. If services are not initiated within 180 days of the date on the county department's written notice to the consumer, the slot reverts for use by the next applicant on the waiting list, if applicable.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR 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 MR 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/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Part E of Form SS-1645, Home and Community Based Service Report, indicating the consumer's choice of care.

d. HCBS MR 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 MR waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

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 SS-1104-0, 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 ICP 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.

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 MR 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).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modifications, supported employment, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.41(249A).

441—83.67(249A) Individual comprehensive plan or service plan. An individual comprehensive plan (ICP) or service plan shall be prepared and utilized for each HCBS MR waiver consumer. The ICP or 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. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires. The service plan or ICP shall incorporate the concept of managed care. The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

83.67(1) A listing of all services received by a consumer at the time of waiver program enrollment.

83.67(2) For supported community living consumers the plan shall include identification of:

a. The consumers' living environment at the time of waiver enrollment.

b. The number of hours per day of on-site staff supervision needed by the consumer.

c. The number of other waiver consumers who will live with the consumer in the living unit.

83.67(3) Rescinded IAB 1/4/95, effective 3/1/95.

83.67(4) An identification and justification of any restriction of a consumer's rights including, but not limited to:

a. Maintenance of personal funds.

b. Self-administration of medications.

83.67(5) The name of the service provider responsible for providing the service.

83.67(6) The service funding source.

83.67(7) The amount of the service to be received by the consumer.

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.

"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.

"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.

"Individual comprehensive plan (ICP)" (also known as individual program 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 involves more than one provider.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written, goal-oriented plan of services developed for a consumer by the consumer and the provider.

"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.

"Iowa Foundation for Medical Care" is the entity designated by the federal government to be the peer review organization for the state of Iowa.

"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 the mentally retarded, 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.

"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.

"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.

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; eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution; or be eligible for medically needy.

c. Be aged 1 month to 64 years.

d. Be a U.S. citizen and Iowa resident.

e. Be currently a resident of a medical institution and have been for at least 30 consecutive days at the time of initial application for the brain injury waiver.

f. Be determined by the Iowa Foundation for Medical Care as in need of intermediate care facility for the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.

g. Be assessed by the Iowa Foundation for Medical Care 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.

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.

83.82(2) *Need for services.*

a. The consumer shall have an individual comprehensive plan approved by the department which is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed prior to services provision and annually thereafter.

The case manager shall establish the interdisciplinary team for the 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 using the following criteria:

(1) The assessment shall be based, in part, on information provided to the Iowa Foundation for Medical Care.

(2) Individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) ICPs for consumers 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 EPSDT and receives a determination of whether EPSDT is appropriate.

(4) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee. 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 ICP. The rationale must contain sufficient information for the division of medical services designee, or for an ICF/MR level of care consumer, the designee of the county of legal settlements board of supervisors, 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 monthly cost of brain injury waiver services shall not exceed $2,650 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Access to HCBS BI waiver services for adult persons meeting the ICF/MR level of care shall be limited to persons who are residing in an ICF/MR and who have resided there for at least 30 days immediately preceding waiver application. In addition, waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25. Each county shall inform the department regarding the number of payment slots desired by April 1 and October 1 of each year. A county may choose to establish no payment slots under the HCBS BI waiver.

a. The payment slots shall be on a county basis for adults with legal settlement in a county and on a statewide basis for children and adults without a county of legal settlement.

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 shall be put on a waiting list shall be sent to the person by the department.

83.82(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS BI waiver program which require the ICF/MR level of care.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS BI program services as documented by the date of the consumer's signature on Form SS-1645-0. 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.

(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.

The county shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

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. The discharge planner shall provide to the Iowa Foundation for Medical Care (IFMC) review coordinator 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 IFMC review coordinator shall inform the discharge planner 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. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the consumer's choice of caregiver. This shall be arranged by the medical facility discharge planner.

d. The medical facility discharge planner shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's ICP 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 IFMC 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 SS-1104-0, 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.

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 services, adult day care, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.43(249A).

441—83.87(249A) Individual comprehensive plan. An individualized comprehensive plan (ICP) shall be prepared and utilized for each HCBS BI waiver consumer. The ICP 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 ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires.

83.87(1) *Information in plan.* The plan shall be in accordance with rule 441—24.44(225C) 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 consumers the plan shall include identification of:

(1) The consumers' 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.

83.87(2) *Case plans for consumers aged 20 or under.* Case plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment plans (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those programs.

Case plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee, or when a county voluntarily chooses to participate, by the county board of supervisors, designee or the division of medical services designee. 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 Iowa Foundation for Medical Care shall assess the consumer annually and certify the consumer's need for long-term care services. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

83.87(4) *Case file.* The Medicaid case manager must ensure that the consumer case file contains the consumer's ICP and, if the county is voluntarily participating, the county's final approval of service costs and the following completed forms:

a. Eligibility for Medicaid Waiver, Form 470-0563.

b. Home- and Community-Based Service Report, Form 470-0660.

c. Medicaid Home- and Community-Based Payment Agreement, Form 470-0379.

d. Consumer Data Entry, Form 470-3280.

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 individual comprehensive plan (ICP).

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c. Services that do not require authorization from the managed health care provider.

Providers of medical service shall examine the card 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.* 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 physician or clinic:

a. The physician treats a disproportionate share of Medicaid patients in the physician's current practice.

b. A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

Other exceptional situations may be considered as special demonstration projects on a case-by-case basis. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the division of medical services and provide sufficient documentation that they fit one or more of the special situations.

A physician or clinic 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 division of medical services or its designee in writing. 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 physician below the physician's new maximum. 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. Disenrollment may be approved for good cause reasons such as, but not limited to, inability after reasonable effort to establish or maintain a satisfactory physician-patient relationship with the recipient. Documentation of the good cause reason for disenrollment will be included with or attached to the disenrollment request. The division shall respond as to whether the disenrollment request is approved within 30 days. 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 MHAP and MSACP programs and do not require authorization (see rules 441—88.61(249A) and 88.81(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. Other practitioners (physical therapy, audiology, rehabilitation agency, nurse midwife, certified registered nurse anesthetists).

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.

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.

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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 598.21, subsection 4, 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.

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, 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.

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 fee shall be charged at the time of initial application and any subsequent application for services. The application fee shall be paid to the local child support recovery unit by the individual prior to services being 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.

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 section 252B.15 and section 252D.17 as amended by 2000 Iowa Acts, House File 2135, section 2.

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) Setoff against state income tax refund or rebate. A claim against a responsible person's state income tax refund or rebate will be made by the department when a support payment is delinquent as set forth in Iowa Code section 421.17(21). A claim against a responsible person's state income tax refund or rebate shall apply to support which the department is attempting to collect.

95.6(1) The department shall submit to the department of revenue and finance by the first day of each month, a list of responsible persons who are delinquent at least $50 in support payments.

95.6(2) The department shall mail a pre-setoff notice, to a responsible person when:

a. The department is notified by the department of revenue and finance that the responsible person is entitled to a state income tax refund or rebate; and

b. The department makes claim to the responsible person's state income tax refund or rebate. The presetoff notice will inform the responsible person of the amount the department intends to claim and apply to support.

95.6(3) When the responsible person wishes to contest a claim, a written request shall be submitted to the department within 15 days after the pre-setoff notice is mailed. 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 a responsible person, as determined by the department of revenue and finance, shall be released by the department of revenue and finance 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 in writing and received by the department within 15 days after the mailing date of the pre-setoff notice.

95.6(5) Support recovery will make claim to a responsible person's state income tax refund or rebate when all current support payments or regular payments on the delinquent support were not paid for 12 months preceding the month in which the pre-setoff notice was mailed. A regular payment toward delinquent support is defined as making a monthly payment. The state income tax refund of a responsible person may be claimed by the office of the department of inspections and appeals or the college aid program even if no claim for payment of delinquent support has been made by support recovery.

95.6(6) The department shall notify a responsible person of the final decision regarding the claim against the tax refund or rebate by mailing a final disposition of support recovery claim notice to the responsible person.

95.6(7) Application of setoff. Setoffs shall be applied as provided in rule 441—95.3(252B).

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4.

441—95.7(252B) Offset against federal income tax refund and federal nontax payment. A claim against a responsible person's federal income tax refund or federal nontax payment will be made by the department when delinquent support is owed.

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 and the support shall have been delinquent for three months.

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.

a. The amount distributed to an obligee shall be the amount remaining following payment of a support delinquency assigned to the department. Prior to receipt of the amount to be distributed, the obligee shall sign Form 470-2084, Repayment Agreement for Federal Tax Refund Offset, agreeing to repay any amount of the offset the Department of the Treasury later requires the department to return. 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 receive a preoffset notice in writing, using address information available from the Department of the Treasury, stating the amount of the delinquent support certified for offset.

a. Individuals who wish to dispute the offset must notify the department within the time period specified in the preoffset notice.

b. Upon receipt of a complaint disputing the offset, the department shall conduct a review to determine if there is a mistake of fact and respond to the obligor 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 decrease in, or elimination of, an amount referred for setoff.

95.7(7) When an individual does not respond to the pre-setoff 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.

a. The obligor shall have 15 days from the date of the notice to the obligor under this subrule to contest the offset by initiating an administrative appeal pursuant to 441—subrules 7.8(1) and 7.8(2). The obligor shall provide the department with a copy of the Department of the Treasury notice. 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.

The department shall refund the amount incorrectly set off to the obligor unless the obligor agrees to apply the refund of the incorrect offset to any other support obligation due. Prior to the receipt of the refund, the obligor shall sign Form 470-2082, Adjustment of Federal Tax or Nontax Offset Agreement, agreeing to repay any amount of the offset the Department of the Treasury later requires the department to return.

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.

441—95.8(96) Child support setoff of unemployment benefits. When job service notifies the child support recovery unit that an individual who owes a child support obligation being enforced by the child support recovery unit has been determined to be eligible for job insurance benefits, the unit will enforce a child support obligation owed by an obligor but which is not being met by setoff of job 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 job insurance benefits by initiating a withholding of income pursuant to Iowa Code chapter 252D and 441—Chapter 98, Division II, or a garnishment action pursuant to Iowa Code chapter 642. The amount to be withheld through a withholding or garnishment of unemployment benefits shall not exceed the amount specified in 15 U.S.C. 1673(b).

95.8(2) A receipt of the payments intercepted through job insurance benefits will be provided once a year, upon the request of an absent parent 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—95.20(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.

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 subrule 95.14(3).

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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◊Two ARCs
*Effective date of 95.1, definition of "Date of collection," and 95.3 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 15, 1999; delayed until the end of the 2000 Session of the General Assembly at its meeting held October 11, 1999.

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, except for child care services where persons must be income eligible:

(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:

Family Size	For Child Care Monthly Gross Income			All Other Services Monthly Gross Income Below
	A	B	C	
1 Member	$ 696	$ 974	$1,219	$ 583
2 Members	938	1,313	1,641	762
3 Members	1,179	1,651	2,064	942
4 Members	1,421	1,989	2,486	1,121
5 Members	1,663	2,328	2,910	1,299
6 Members	1,904	2,666	3,332	1,478
7 Members	2,146	3,004	3,755	1,510
8 Members	2,388	3,343	4,178	1,546
9 Members	2,629	3,681	4,601	1,581
10 Members	2,871	4,019	4,701	1,612

For child care, Column A, add $242 for each additional person over 10 members. For child care, Column B, add $338 for each additional person over 10 members. For child care, Column C, add $100 for each additional person over 10 members. For other services, add $33 for each additional person over 10 members.

Column A is used to determine income eligibility when funds are insufficient to serve additional families beyond those already receiving services or requiring protective child care and applications are being taken from families who are at or below 100 percent of the federal poverty guidelines and in which the parents are employed at least 28 hours per week or are under the age of 21 and participating in an educational program leading to a high school diploma or equivalent or from 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 or education program. (See 441—paragraphs 170.2(3)*"a"* and *"c."*)

Column B is used to determine income eligibility when funds are insufficient to serve additional families beyond those already receiving services or requiring protective child care and applications are being taken from families with an income of more than 100 percent but not more than 140 percent of the federal poverty level whose members are employed at least 28 hours per week (see 441—paragraph 170.2(3)"*d*") or when there is adequate funding and no waiting lists and applications are being taken from families applying for services, with the exception of families with children with special needs.

Column C is used to determine income eligibility for families with children with special needs.

(3) Foster child status. For a child residing in foster care, the foster child shall be considered a family of one and the child's income shall be the only income considered in determining eligibility for child care services.

(4) 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.

(5) A person who is part of the family investment program, or whose earned income was taken into account in determining the needs of the family investment program recipient, is eligible for child care assistance without regard to income if there is a need for child care services.

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. For child care services, the income of the parent(s) with whom the teen parent(s) resides.

y. For child care services for children with special needs, income spent on any regular ongoing cost is specific to that child's disability.

z. Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

aa. For child care services, if a recipient of the family investment program, or one whose earned income was taken into account in determining the needs of the family investment program recipient, is excluded from the family investment program due to receiving Supplemental Security Income, the income received from the Supplemental Security Income recipient is excluded in determining gross income. The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income is also excluded.

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) A person who is deemed to be eligible for state child care assistance program 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, provider reimbursement methodology and rates, and any other requirements established by the department.

This rule is intended to implement Iowa Code section 234.6 and 1999 Iowa Acts, House File 761, division III.

441—130.4(234,239B) 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(234,239B), but not those receiving services without regard to income due to a protective service situation or for rehabilitative treatment services. 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.* The monthly income chart and fee schedule for child care services in a licensed child care center, an exempt facility, a registered family or group child care home, a nonregistered family child care home, or in-home care are shown in the following table:

Monthly Income Increment Levels According to Family Size

Income Increment Levels	1	2	3	4	5	6	7	8	9	10	Half-Day Fee
A	661	891	1120	1350	1579	1809	2039	2268	2498	2727	.00
B	696	938	1179	1421	1663	1904	2146	2388	2629	2871	.50
C	735	990	1245	1500	1756	2011	2266	2521	2776	3032	1.00
D	776	1045	1315	1584	1854	2123	2393	2662	2932	3201	1.50
E	819	1104	1389	1673	1958	2242	2527	2811	3096	3381	2.00
F	865	1166	1466	1767	2067	2368	2668	2969	3269	3570	2.50
G	914	1231	1548	1866	2183	2500	2818	3135	3453	3770	3.00
H	965	1300	1635	1970	2305	2641	2976	3311	3646	3981	3.50
I	1019	1373	1727	2081	2434	2788	3142	3496	3850	4204	4.00
J	1076	1450	1823	2197	2571	2945	3318	3692	4066	4439	4.50
K	1136	1531	1926	2320	2715	3109	3504	3899	4293	4688	5.00
L	1200	1617	2033	2450	2867	3284	3700	4117	4534	4950	5.50
M	1267	1707	2147	2587	3027	3467	3908	4348	4788	5228	6.00

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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 foster group care and 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) Unless otherwise provided for in 441—Chapter 156, rates for shelter care shall not exceed $83.69 per day based on a 365-day year.

(2) For the fiscal year beginning July 1, 2000, the maximum reimbursement rates for services provided under a purchase of social service agency contract (adoption; local purchase services including adult day care, adult support, adult residential, community supervised apartment living arrangement, sheltered work, work activity, and transportation; shelter care; family planning; and independent living) shall be the same as the rates in effect on June 30, 2000, except under any of the following circumstances:

1. If a new service was added after June 30, 2000, the initial reimbursement rate for the 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.

For adoption, the only time a provider shall be considered to be offering a new service is if the provider adds the adoptive home study, the adoptive home study update, placement services, or postplacement services for the first time. Preparation of the child, preparation of the family and preplacement visits are components of the services listed above.

For local purchase services, a provider shall be considered to be offering a new service when adding a service not currently purchased under the social services contract. For example, the contract currently is for adult support, and the provider adds a residential service.

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.

For family planning, the only time the provider shall be considered to be offering a new service is when a new unit of service is added by administrative rule.

For independent 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 an independent living cluster site, the addition of a new site does not constitute a new service.

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.

2. 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.

3. For the fiscal year beginning July 1, 2000, 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. The maximum reimbursement rate shall be $83.69 per day. If the department reimburses the provider at less than the maximum rate, but the provider's cost report justifies a rate of at least $83.69, the department shall readjust the provider's reimbursement rate to the actual and allowable cost plus the inflation factor or $83.69, whichever is less.

4. For the fiscal year beginning July 1, 2000, the purchase of service reimbursement rate for adoption, independent living services, and shelter care shall be increased by 5 percent of the rates in effect on June 30, 2000. The 5 percent increase in shelter care rates results in a per diem increase of $3.99. The shelter care providers actual and allowable cost plus inflation shall be increased by $3.99. For state fiscal year 2001 beginning July 1, 2000, the established statewide average actual and allowable rate shall be increased by $3.99.

5. Rescinded IAB 6/28/00, effective 7/1/00.

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. The department shall not make payment for services provided prior to the client's application, eligibility determination, and referral. See *"b"* below for an exception to this rule.

The following forms shall be used by the department to authorize services:

Form 470-0622, Referral of Client for Purchase of Social Services.

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.

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.

441—150.8(234) Provider advisory committee. The provider advisory committee serves in an advisory capacity to the department, specifically to the bureau of purchased services. The provider advisory committee is composed of representatives from member provider associations as appointed by the respective associations. Individual representatives from provider agencies having a purchase of service contract but not belonging to an association may become members of the provider advisory committee upon simple majority vote of the committee members at a meeting. A representative of the purchase of service fiscal consultant is a nonvoting member. Departmental representatives from the bureau of purchased services, the office of the deputy director of field operations, the division of adult, children and families services, and the division of mental health and developmental disabilities are also nonvoting members.

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 2000 Iowa Acts, House File 2555, section 1, subsection 1, paragraph *"d,"* and Senate File 2435, section 31, subsection 7.

441—150.10 to **441—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

PREAMBLE

In order for the counties to fulfill their duties pursuant to the approved county management plans, counties must have service agreements with providers of mental health, mental retardation and developmental disabilities services. The Iowa State Association of Counties has requested the assistance of the department in negotiating contracts on behalf of the counties. The following rules set forth the terms and conditions for contracting that will be used by the department when contracting on behalf of counties with providers of local purchase services for adults with mental illness, mental retardation and developmental disabilities.

The department, within the limits of current resources, will negotiate contracts on behalf of counties beginning July 1, 1997. The initial contracts will be negotiated by amending the existing purchase of social service agency contract, using Form 470-0630, Amendment or Renewal of Iowa Purchase of Services Agency Contract, to reflect the contractual relationship between the provider and the counties. The amendment will be effective for the time period ending June 30, 1998.

441—150.21(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.

"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 within 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.

"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.

"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.

(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 foster group care and 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) 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.

(3) Costs of reference publications and subscriptions for program-related materials are limited to $500 per year.

(4) 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.

(5) 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.

(6) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (5) above.

(7) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is $40,000 annually.

(8) 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.

(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) For the fiscal year beginning July 1, 2000, the maximum reimbursement rates for local purchase services, including adult day care, adult support, adult residential, community supervised apartment living arrangement, sheltered work, work activity, and transportation shall be the same as the rates in effect on June 30, 2000, except under any of the following circumstances:

1. If a new service was added after June 30, 2000, the initial reimbursement rate for the 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.

For local purchase services, a provider shall be considered to be offering a new service when adding a service not currently purchased under the social services contract. For example, the contract currently is for adult support, and the provider adds a residential service.

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.

2. 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.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

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 subparagraphs 150.22(7)*"a"*(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in paragraph 150.22(5)*"k."*

(3) Tests for relatedness shall be those specified in rule 441—150.21(234) and paragraph 150.22(5)*"o."* Authorized department or county personnel, the purchase of service fiscal consultant, and state, county, or federal audit personnel 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. 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.

s. Rate formula. Paragraph 150.22(7)*"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 150.22(7), paragraphs *"a"* to *"r."*

(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.

150.22(8) *Client eligibility and referral.* To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the county. The county is not obligated to make payment for services provided prior to the client's application, eligibility determination, and referral.

The following forms shall be used by the county to authorize services:

Form 470-0622, Referral of Client for Purchase of Social Services, or the process authorized by the referring county.

150.22(9) *Client fees.* The provider shall agree not to require any fee for service from clients referred pursuant to the contract unless a fee is required by the referring county and is consistent with federal and state regulation.

The provider shall collect fees due from clients, if requested by the referring county. The provider shall maintain records of fees collected, and these records shall be available for audit by the referring county 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 central point of coordination or designee.

150.22(10) *Billing procedures.* At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, or the form agreed upon between the provider and the referring county, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred. Complete invoices shall be sent to the county responsible for the client for approval and forwarding for payment. More frequent billings may be permitted on an exception basis by the referring county.

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.

150.22(11) *Review of actions.* A provider who is adversely affected by a departmental decision may request a review by the department. 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 10 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 10 days.

b. When dissatisfied with the response, the provider shall submit to the regional administrator within 10 days the original request, the response received, and any additional information desired. The regional administrator 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 10 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 regional administrator or designee.

d. The provider may appeal this decision within 10 days to the director of the department, who shall issue the final department decision within 14 days.

The department shall notify the applicable counties of any request for review and the decision reached in response to the request.

A provider who is adversely affected by a county decision may request a review in accordance with procedures established by the county pursuant to the approved county management plan.

150.22(12) *Review of financial and statistical reports.* The provider's general financial records shall be available for review by authorized department and county personnel, the purchase of service fiscal consultant, and state, county, and federal audit personnel. The purpose of the review is to determine if expenses reported for the purpose of establishing the rate have been handled as required under subrule 150.22(7). 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.

150.22(13) *Notification of changes.* The provider shall, prior to implementation whenever possible, notify the assigned project manager of any changes in the provider's organization or delivery of service which may affect compliance with any terms and conditions of the contract. If prior notice is not possible, the provider shall notify the project manager within one working day of the change.

These rules are intended to implement Iowa Code section 234.6 and 2000 Iowa Acts, Senate File 2435, section 31, subsection 7.

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"Substance abuse treatment supervisor" means the same as defined in the substance abuse commission rule 643—3.1(125) as treatment supervisor.

"Treatment foster parent" means an individual who is licensed to provide foster care and is trained to provide behavioral management for children in therapeutic foster care.

"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.

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 on Form CS-3104-0, Assignment of Support Payments-Foster Care.

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	$14.00
6 through 11	14.78
12 through 15	16.53
16 and over	16.53

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 regional administrator 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. When foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus $4.94 per day for extra expenses associated with the child's special needs.

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. When a treatment foster family provides care to a child receiving behavioral management services for children in therapeutic foster care pursuant to 441—subrule 185.62(3), the foster family shall be paid the basic maintenance rate plus $14.80 per day.

e. When a human services area administrator determines that a foster family is providing care comparable to behavioral management services for children in therapeutic foster care pursuant to 441—subrule 185.62(3), 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 $14.80 per day. Foster families receiving this difficulty of care payment shall meet the requirements as found in 441—paragraph 185.10(8)*"b."* If the human services area administrator determines that a foster family has been providing this level of care prior to November 1, 1993, and the department has been paying the foster family difficulty of care payments in excess of $14.80 per day, the foster family shall continue to receive the higher payment for the duration of the time the human services area administrator determines that the foster family is providing care comparable to that provided to a child receiving behavioral management services for children in therapeutic foster care.

If the review organization determines that the child has been receiving family foster care core three services prior to November 1, 1993, and if the foster family has been receiving difficulty of care payments in excess of $14.80 per day, the department shall continue to pay the foster family the higher payment for the duration of the time the review organization authorizes family foster care core three services.

f. The difficulty of care maintenance payment shall be reviewed every six months or earlier if the child's situation changes.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form SS-2605-0, Foster Family Placement Contract.

156.6(5) *Payment method.* All maintenance payments to foster families supervised by the department or a licensed private child caring agency shall be made directly to the foster family by the department.

156.6(6) *Compliance transition period.* Rescinded IAB 6/9/93, effective 8/1/93.

This rule is intended to implement Iowa Code section 234.38 and 2000 Iowa Acts, Senate File 2435, section 31, subsection 6.

441—156.7(234) Purchase of family foster care services.

156.7(1) *Types of services.* The department may develop a contract pursuant to 441—Chapter 152 with a child-placing agency licensed pursuant to rule 441—108.7(234) for any of the following family foster care services:

a. Family foster care supervision.

b. Family foster care treatment services.

c. Foster family home studies.

156.7(2) *Family foster care supervision.* Purchased family foster care supervision shall meet the following requirements:

a. Services shall be provided in accordance with rule 441—108.7(234) and shall include visits with the child and foster family at a minimum frequency of not less than one visit every 35 days.

b. Services shall:

(1) Occur on a face-to-face basis.

(2) Be directed toward the child and shall include the child or the foster family.

(3) Be delivered in whatever locations the referral worker's social casework findings indicate are appropriate to ensure that all reasonable efforts are being made to meet the child's needs.

c. The department shall determine when to refer a child to a private agency for family foster care supervision, and shall specify the maximum number of units and the duration of services authorized on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

d. Units of service shall be provided in one-half hour increments.

e. Services shall be reimbursed for each billable unit of family foster care supervision authorized and delivered. The unit rate shall be determined according to the policies in rules 441—185.101(234) to 441—185.108(234).

f. The provider shall develop a service plan which meets the following requirements:

(1) The provider shall develop a service plan for each child receiving supervision services. The service plan shall be developed in collaboration with the referral worker, family, child, and foster parents unless the service plan contains documentation of the rationale for not involving one of these parties.

(2) Service plans shall be developed within 30 calendar days of initiating services. The provider shall document the dates and content of any collaboration on the service plan.

(3) Service plans shall describe the supervision service goals and objectives, the supervision services to be provided, and persons responsible for providing the supervision services.

(4) Each service plan shall identify the individual who will monitor the supervision services being provided to ensure that they continue to be necessary and consistent with the case permanency plan developed or modified by the referral worker.

(5) Each service plan shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of supervision services or when any changes to the case permanency plan are made. The person reviewing the plan shall sign and date each review. If the review determines that the service plan is inconsistent with the case permanency plan, the provider's service plan shall be revised to reflect case permanency plan expectations.

(6) The provider shall provide a copy of all service plans and plan reviews to the family and referral worker, unless otherwise ordered by the court.

g. The provider shall receive approval from the referral worker on Form 470-3055, Referral of Client for Rehabilitative and Supportive Services, before increasing the amount or duration of services beyond what was previously approved. Based on their ongoing assessment activities, providers may communicate family service needs they believe are not adequately addressed in the department case permanency plan at any time during their provision of services.

h. The provider shall prepare a written report of termination activities which identifies the reason for termination, date of termination, and the recommended action or referrals upon termination.

i. The provider shall maintain a confidential individual record for each child receiving supervision services. The record shall include the following:

(1) Case permanency plan as supplied by the referral worker.

(2) Documentation of billed services which shall include: the specific services rendered, the date and amount of time services were rendered, who rendered the services, the setting in which services were rendered, and updates describing the client's progress.

(3) All service plans and service plan reviews developed by the agency.

(4) Correspondence with the referral worker regarding changes in the case permanency plan or service plan or requests for approval of additional services and any relevant evaluation activities.

(5) Progress reports 90 calendar days after initiating services and every 90 calendar days thereafter which summarize progress and problems in achieving the goals and objectives of the service plan. The progress report shall be written in conjunction with the service plan review and shall be completed no more than 15 calendar days before the report is due or 15 calendar days after the report is due. The provider shall provide a copy of all detailed progress reports to the family and referral worker, unless otherwise ordered by the court.

(6) Termination reports.

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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(78GA,SF2193) 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(78GA,SF2193) 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(78GA,SF2193).

441—161.3(78GA,SF2193) 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(78GA,SF2193) 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, Division of Medical Services, Fifth Floor, 1305 E. Walnut, 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 per agreement as a processing payment and 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 of money in the medical assistance appropriation.

These rules are intended to implement 2000 Iowa Acts, Senate File 2193, sections 4 and 5.

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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 2000 Iowa Acts, Senate File 2193, which establishes an overall goal of moving toward a balanced, comprehensive, affordable, high quality long-term care system.

441—162.1(78GA,SF2193) 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 as amended by 2000 Iowa Acts, Senate File 2193, section 14.

"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 as amended by 2000 Iowa Acts, Senate File 2193, section 14; 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 as amended by 2000 Iowa Acts, Senate File 2193, section 13, 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 2000 Iowa Acts, Senate File 2193, section 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(78GA,SF2193) 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(78GA,SF2193) 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 three-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 three 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. Grants 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(78GA,SF2193) 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(78GA, SF2193) 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(78GA,SF2193) 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(78GA,SF2193) Project contracts. The funds for approved applications shall be awarded through a contract entered into by the department and the applicant.

441—162.7(78GA,SF2193) 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(78GA,SF2193) 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(78GA,SF2193) 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 2000 Iowa Acts, Senate File 2193, section 6.

[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]

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 for projects that are comprehensive in scope and 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
FOSTER CARE PROJECT GRANTS
Rescinded IAB 9/8/99, effective 11/1/99

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 SS-1203-3.

b. Registered group child care home. A group child care 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. A family child care home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

d. Relative care. An adult relative who provides care in the relative's own home solely for a related child may receive payment for child care services when selected by the parent.

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, Minimum Health and Safety Requirements for Nonregistered Care Home Providers, and Form 470-2890, Payment Application for Nonregistered Providers. Form 470-2890 shall be signed by the provider and returned to the department within 15 days before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include: minimum health and safety requirements, limits on the number of children for whom care may be provided, unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order, and 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, Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890, Payment Application for Nonregistered Providers. Form 470-2890 shall be signed by the provider and returned to the department within 15 days before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include: minimum health and safety requirements, limits on the number of children for whom care may be provided, unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order, and conditions that warrant nonpayment.

g. Exempt facilities. Child care facilities which are exempt from licensing or registration as defined in Iowa Code section 237A.1 may receive payment for child care services when selected by a parent.

h. Record checks for nonregistered family child care homes. If a nonregistered child care provider, including a relative, wishes to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form 470-0643, Request for Child Abuse Information, and Form 595-1489, State of Iowa Non-Law Enforcement Record Check Request, Form A, for the provider as though the provider either is being considered for registration or is registered to provide child care, for anyone having access to a child when the child is alone, and anyone living in the home. The county office worker or the PROMISE JOBS worker shall provide the individual with the necessary forms. The provider shall return the forms to the county office or PROMISE JOBS worker for submittal to the division of adult, children and family services.

If there is a record of founded child abuse naming a nonregistered child care provider, anyone having access to a child when the child is alone, or any individual living in the home of the nonregistered child care provider as being a perpetrator of child abuse, or a criminal conviction for any of the same individuals, the division shall notify the regional office to perform an evaluation following the process defined at 441—subrule 110.7(3) or rule 441—110.31(237A). If any of the individuals 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 regional administrator or designee shall notify the applicant, and a copy of that notification shall be forwarded to the county attorney, the county office, and the PROMISE JOBS worker, if applicable. A person who continues to provide child care in violation of this law 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.* An individual program plan shall be developed by the child care provider for each child within 30 days after placement when the need for service was established under 170.2(3)*"d."* The program plan shall be supportive of the service worker's case plan. The program plan shall contain goals, objectives, services to be provided, and time frames for review.

170.4(7) *Payment.*

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	Day Care Center	Registered Family Home	Registered Group Home	Nonregistered Family Home
Infant and Toddler	$12.45	$10.00	$9.00	$8.19
Preschool	$10.50	$ 9.00	$8.55	$7.19
School Age	$ 9.00	$ 9.00	$8.33	$7.36

Table II
Half-Day Rate Ceilings for Special Needs Care

Age Group	Day Care Center	Registered Family Home	Registered Group Home	Nonregistered Family Home
Infant and Toddler	$48.00	$15.75	$12.38	$10.24
Preschool	$28.13	$14.63	$12.38	$ 8.99
School Age	$28.04	$13.50	$11.25	$ 9.20

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(3) The effective date of the rate for a new service shall be the effective date of a new contract or the effective date of the contract amendment adding that new service to an existing contract unless a later effective date is agreed to by both parties.

(4) The effective date of the rate for an existing service shall be the first of the month following the month in which the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form 470-3404, and all necessary supportive documentation and disclosures are received by the bureau of purchased services by the fifteenth of the month.

k. Once a negotiated rate is established based on the provisions of this subrule, it shall not be changed or renegotiated during the time period of this rule except in the following circumstances:

(1) By mutual consent of the provider and the regional administrator of the host region based upon the factors delineated at paragraph 185.112(1)*"f,"* except that rates shall not be changed or renegotiated for the period of July 1, 2000, through June 30, 2001.

(2) In accordance with paragraph 185.112(6)*"b,"* except that rates shall not be changed or renegotiated for services not assumed by a new provider for the period of July 1, 2000, through June 30, 2001.

(3) Rates may be changed when funds are appropriated for an across-the-board increase. Effective July 1, 2000, a 5 percent across-the-board cost-of-living adjustment will be applied.

185.112(2) *New services.* When a new provider contracts to provide a rehabilitative treatment or supportive service or an existing provider adds a new rehabilitative treatment or supportive service on or after January 1, 1998, the rate for the new service shall be established based on a payment rate negotiated in accordance with subrule 185.112(1) using the weighted average rate for that service in lieu of an existing rate as the starting point for negotiations.

a. If an existing provider already has a rate for a similar service and wishes to establish a second rate for that service, the starting point for rate negotiations for the second rate shall be the starting point used in negotiations for the provider's already established rate for that similar service.

b. If an existing provider has more than one rate for a similar service and wishes to establish an additional rate for that service, the starting point for rate negotiations shall be established by the regional administrator of the host region and shall be one of the following: the starting point of that provider's established rate for the similar service most closely resembling the proposed service, or the simple average of the starting points of all of the provider's established rates for similar services.

c. The weighted average rate is the weighted average rate for each service as of July 1, 1997, as previously established in accordance with subrule 185.109(1).

d. For those services where no weighted average rate has been established because there are less than four rates existing for that service or for newly developed rehabilitative treatment and supportive services, the department shall determine the cost of that service by requiring financial and statistical reports reflecting the costs for the new service to be submitted in accordance with rules 441—185.102(234) to 441—185.107(234). Initial projected rates established in accordance with this subrule shall become effective in accordance with subrule 185.107(2).

The report of actual costs pursuant to paragraph 185.103(1)*"b"* shall be used only to establish the historical costs of the new service which shall be used as the starting point in the rate negotiation process. The negotiated rate established in accordance with subrule 185.112(1) based upon the actual cost report shall become effective in accordance with paragraph 185.112(1)*"j."*

185.112(3) *Rate resolution process.* The rate resolution process may be used when the department and a provider are unable to agree upon a rate for a service within 60 days of initiating rate negotiations.

a. This process involves obtaining an independent mediator who is agreeable to both parties.

b. The cost of the mediator shall be borne equally by the provider and the department. Neither party to the mediation shall be liable for paying for more than that party's share of the cost for eight hours of mediation unless this is mutually agreed upon prior to initiation of the mediation process.

c. The rate resolution process must be concluded within 60 days of its initiation.

d. The mediator shall not make rate-setting decisions. The role of the mediator is to facilitate discussions between the parties in an effort to help the parties reach a mutual agreement.

185.112(4) *Failure to reach agreement on rates.* In the event the department and the provider are unable to reach agreement on a rate, the following procedures apply:

a. If the department and an existing provider are unable to reach agreement on a negotiated rate for an existing service with a published rate within 60 days of initiating negotiations or by June 30, 1998, whichever comes first, the rate resolution process may be used.

(1) Whether or not the rate resolution process is used, if agreement is not reached by September 30, 1998, the service shall be deleted from the provider's rehabilitative treatment and supportive services contract no later than November 30, 1998.

(2) If agreement is reached, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

b. In the event the department and an existing provider are unable to reach agreement on a rate for a new service or an existing service without a published rate within 60 days of initiating rate negotiations, the rate resolution process may be used.

(1) If the rate resolution process is not used, and agreement is not reached within 120 days of initiating negotiations, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.
2. For existing services without a rate, the contract shall be amended to delete this service from the contract.

(2) If the rate resolution process is used and no rate is agreed upon within 60 days of referral to the rate resolution process, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.
2. For existing services without a rate, the contract shall be amended to delete this service from the contract.
3. If agreement is reached within the required time frames in either of the above situations, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

c. In the event the department and a new provider are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, the rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of the rate resolution process, no rate shall be established and the services in question shall not be a part of any approved contract for rehabilitative treatment and supportive services. In the event that the department and a new provider cannot reach agreement on any rates, the contract shall be denied.

d. In all cases, a service for which a negotiated rate has not been established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), on or before September 30, 1998, shall be terminated from the provider's contract for rehabilitative treatment and supportive services no later than November 30, 1998.

e. The department shall not be liable for payment for any rehabilitative treatment or supportive service that does not have a rate established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), that is provided after November 30, 1998.

185.112(5) *Public agencies.* Public agencies shall be required to demonstrate their compliance with paragraph 185.106(3)*"d."*

185.112(6) *Interruptions in a program.*

a. If a provider assumes the delivery of a program from a related party provider as defined at paragraph 185.105(11)*"c"* or 441—subrule 152.2(18), the rate for the new provider shall remain the same as the rate established for the former provider. The rate for the new provider shall also remain the same as for the former provider if the difference between the former and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from sole proprietorship to corporation).

DIVISION VII
BILLING AND PAYMENT PROCEDURES

441—185.121(234) Billing procedures. At the end of each month the provider agency shall prepare Form AA–2241–0, 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 and each program. Complete invoices shall be sent to the department county office responsible for the client for approval and forwarding for payment.

Providers shall never bill for more than one month of service. A separate invoice is required for each separate month of service, even if the service span overlaps one month.

185.121(1) *Time limit for submitting invoices.* 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 are to be submitted by August 10.

185.121(2) *Resubmittals of rejected claims.* Valid claims which were originally submitted within the time limit specified in 185.121(1) but were rejected because of an error shall be resubmitted as soon as corrections can be made.

185.121(3) *Payment.* Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all invoices concerning rehabilitative treatment and supportive services rendered to clients, provided the invoices shall be subject to audit and adjustment by the department.

441—185.122(234) Recoupment procedures. Public agencies that are reimbursed more than their actual costs are required to refund any excess to the department within four months of the end of their fiscal year. No provision for profit or other increment above cost is intended in OMB Circular A–87 for public agencies. Those public providers subject to this provision who fail to comply with this requirement shall be considered to be in violation of 185.12(1)"*r*" and subject to sanctions. Providers who do not refund any excess payments within six months of the end of their fiscal year shall be given notice in accordance with 185.12(6) and have any and all payments suspended or withheld in accordance with 185.12(7).

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

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CHAPTERS 186 to 199
Reserved

*Rule 185.4(234), subrule 185.8(4) and rule 185.9(234), effective 8/12/93.
**Effective date of 185.22(1)"*d*,"(2)"*d*," and (3)"*d*," 185.42(3), 185.62(1)"*d*,"(2)"*d*," and (3)"*d*," and 441—185.82(234) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 11, 1995.

(7) Attorney fees and court costs necessary to finalize the adoption, limited to the usual and customary fee for the area.

(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 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.

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) The family fails to participate in the renewal process.

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) or 201.7(6) to 201.7(8) 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 children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Non-IV-E children from Iowa residing in another state shall receive medical assistance from the state of residence when the state has adopted the adoption assistance interstate compact and a contract between Iowa and the family's state of residence is completed. Medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

c. Non-IV-E-eligible 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.

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 600.21 and 600.23; and 2000 Iowa Acts, Senate File 2435, section 31, subsection 6.

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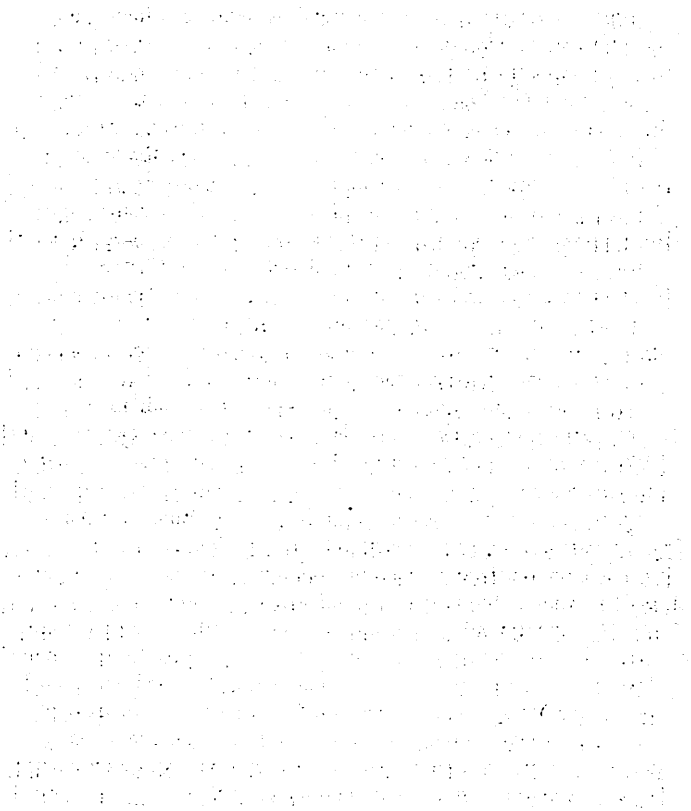

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CHAPTER 52
BIRTH CENTERS

481—52.1(135G) Definitions. For the purpose of these rules the definitions set out in Iowa Code section 135G.2 shall be considered to be incorporated verbatim in the rules. The use of the word "shall" indicates that standard is mandatory.

481—52.2(135G) License. Each facility shall obtain a license (Form 427-0059) from the department. This license shall be:

1. Posted in each facility so the public can see it easily, (III)
2. Valid only for the premises and person named on the license and not be transferable, and (III)
3. Valid for one year from the date of issuance.

52.2(1) To obtain a birth center license for a facility not currently licensed as a birth center the applicant shall:

a. Submit application (Form 427-0087) to the department.

b. Meet all of the requirements contained in this chapter.

c. Submit a letter of intent and a written description of programs and services to be provided.

d. Submit a floor plan which accurately reflects the current status of the building. The floor plan shall show:

(1) Room areas in proportion,
(2) Room dimensions,
(3) Bathrooms,
(4) Window and door locations, and
(5) Use of each room.

e. Submit a photograph of the front and side elevations of the facility.

f. Submit the license fee of $15.

g. Comply with state and local statutes and ordinances applicable at the time of licensure.

h. Have on record a certificate signed by the state fire marshal or deputy state fire marshal which states that fire safety requirements have been met.

i. Submit a report of the most recent approved water test as required by the department of natural resources for public water supplies, if the water supply is from a private source.

j. Arrange for storage of drugs and pharmaceuticals in consultation with the board of pharmacy.

k. Assure laboratory services by having:

(1) A laboratory on the premises supervised by the medical director, or
(2) A signed agreement with a laboratory supervised by a pathologist.

l. Obtain a certificate of need from the health facilities council.

52.2(2) To renew a license the applicant shall:

a. Meet requirements set out in 52.2(1) *"f," "g," "h,"* and *"i."*

b. Submit a description of changes in program and services to be provided and changes in the facility, and

c. Submit application (Form 427-0087) to the Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319, 90 days before the renewal date on the current license.

52.2(3) Variances. A variance from these rules may be granted by the director of the department.

a. To request a variance the licensee shall:

(1) Submit request for variance (Form 427-0080) to the department of inspections and appeals at the address above,

(2) Cite the rule or rules from which a variance is desired,

(3) State why compliance with the rule or rules cannot be accomplished,

(4) Explain alternate arrangements or circumstances which justify the variance, and

(5) Demonstrate that the requested variance will not endanger the health, safety or welfare of any client.

b. Upon receipt of request for a variance the director shall:

(1) Evaluate the alternate arrangements or circumstances which are presented,

(2) Study the probable effect of the requested variance on the health, safety, or welfare of the client, and

(3) Consult with the applicant if additional information is required.

52.2(4) Based on these factors, the variance shall be either granted or denied within 45 days of receipt of request. Variances that are granted may be reviewed at the discretion of the director and revoked as deemed necessary. The approved variance shall remain in effect as long as alternate arrangements or circumstances continue to maintain the health, welfare, and safety of the clients.

52.2(5) Change of ownership. When a birth center is to be sold, transferred, assigned, or leased, the licensee shall:

a. Notify current clients of the pending action at least 30 days before action is taken.

b. Inform the department of the name and address of the purchaser, transferee, assignee or lessee at least 30 days before the action is to be taken, and

c. Submit a written authorization for the department to release requested information, except that which identifies individual mothers or children, to the prospective purchaser, transferee, assignee, or lessee.

(1) Information released shall not include identification of individual clients, and

(2) The purchaser may be obligated to pay for copies of documents.

d. To obtain a license when the ownership of a currently licensed birth center changes, the new applicant shall:

(1) Meet all requirements of 52.2(1)*"a"* through *"j"*; and

(2) Submit application (Form 427-0087) to the department at least 30 days prior to the planned change of ownership.

52.2(6) At least 60 days before a birth center is physically altered, modified, or expanded the licensee shall submit plans to the department for recommendations and approval.

52.2(7) A birth center license may be denied, suspended or revoked if the department finds that a facility has failed to comply with 481—Chapter 52 or Iowa Code chapter 135G.

a. Notice. When the department denies, suspends or revokes a license, the licensee or applicant shall be notified by registered mail or by personal service.

b. Hearing. The applicant or licensee may request a hearing on the decision of the department.

(1) The request must be in writing and must be mailed within 30 days of the receipt of the notice to: Department of Inspections and Appeals, Division of Health Facilities, Lucas State Office Building, Des Moines, Iowa 50319.

(2) The status of the license remains until the final agency action is taken.

(3) The hearing shall be held pursuant to 481—50.6(10A).

c. Appeal. The decision of the hearing officer is a proposed decision and becomes final unless appealed to the director within ten days pursuant to 481—50.6(10A).

52.2(8) Penalties. When a facility is found to be in violation of Iowa Code chapter 135G or 481—Chapter 52, the department may:

a. Impose a fine in an amount up to $500 per day. Determination of the amount of the fine is based on:

(1) The severity of the violation, including the probability that death or serious harm to the health and safety of any person will result or has resulted,

(2) The extent to which the provisions of this chapter and other administrative rules were violated,

(3) Actions taken by the licensee to correct the violations or to remedy situations complained about,

(4) Any previous violations by the licensee.

b. Issue an emergency order immediately suspending or revoking a license when the department determines that any condition in the licensed birth center presents a clear and present danger to the public health and safety.

c. Impose an immediate moratorium on elective admissions to any licensed birth center when the department determines that any condition in the birth center presents a threat to the public health and safety.

d. Maintain action in the name of the state for injunction or other process to enforce Iowa Code chapter 135G and 481—Chapter 52.

Any person who establishes, conducts, manages or operates any birth center without a license shall be guilty of a simple misdemeanor. Each week of continuing violation after conviction shall be considered a separate offense. The department shall enjoin an unlicensed birth center from operating.

481—52.3(135G) Direction. Each birth center, whether organized as a proprietary or voluntary service under sole ownership or corporate group, shall have a governing body with full authority and responsibility for overall policy and fiscal management of the facility and services. The governing body shall:

1. Develop and make available to the department a table of organization which shows the position of each staff member.
2. Be responsible for the appointment of the director of the birth center and a director of medical affairs.

The director of the birth center shall have administrative ability and shall be responsible for the operation and maintenance of the facility. If the director is not a physician with a valid license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy, or a licensed nurse midwife, a licensed nurse midwife shall be appointed director of midwifery services.

The director of medical affairs shall be a licensed physician in good standing with hospital obstetrical privileges and shall advise and consult with the birth center staff and approve policies, procedures and protocols related to midwifery management of care and medical management of pregnancy. These shall relate to birth, postpartum, newborn and gynecologic health care. The director of medical affairs shall periodically review previously developed policies, procedures and protocols and ascertain the need for amendment, if any.

3. Adopt bylaws which include criteria for staff and consultation appointments, delineation of clinical privileges and organization of staff.

481—52.4(135G) Staff requirements. There shall be sufficient professional staff to provide services for operation and maintenance of the birth center.

52.4(1) Clinical staff shall be on duty at all times when clients are present. All clinical staff members and consultants shall hold valid Iowa licenses.

52.4(2) A licensed nurse midwife or licensed physician shall attend each birth. A second nurse or physician shall also be present at each birth. All licensed staff shall be certified annually in basic life support.

52.4(3) Any staff member or volunteer not licensed as a nurse, nurse midwife or physician shall be trained by and be under the supervision of a professional staff member.

52.4(4) All staff shall have an annual medical evaluation by a physician with a valid license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy certifying that the staff member is physically and emotionally capable of performing assigned tasks.

481—52.5(135G) Client selection. Each client served at a birth center shall be confirmed as having a low-risk pregnancy by her physician. The client shall begin prenatal care before 20 weeks after conception. The following list of complications of pregnancy shall require the midwife at the birth center to call and confer with the client's consulting physician to determine if the pregnancy continues to be low risk:

52.5(1) *Previous history.*

a. One or more previous premature labors or history of low birth weight infants (less than 2500 grams),

b. Excessively large previous infants (greater than 4000 grams),

c. Cesarean section,

d. Neonatal loss,

e. Two or more abortions,

f. Fetal loss,

g. Suspected incompetent cervix,

h. Medical indication for termination of pregnancy,

i. Diagnosed abnormalities of genital tract,

j. Need for special neonatal care,

k. Infant with a known or suspected genetic or familial disorder or mental retardation,

l. Severe emotional problem associated with pregnancy or delivery,

m. Hepatitis B.

52.5(2) *Early pregnancy.*

a. Maternal diabetes mellitus,

b. Client less than 18 or more than 35 years of age,

c. Psychiatric disorder,

d. Marked nutritional abnormality (obesity, abnormal stature, low weight for height, etc.),

e. Malignancy,

f. Unresponding urinary tract infection,

g. Suspected ectopic pregnancy,

h. Suspected missed abortion,

i. Severe hyperemesis,

j. Exposure to teratogens (radiation, infection, chemicals),

k. Positive serologic test for syphilis,

l. Pregnancy complicated by medical disease (endocrine, renal, cardia, hypertensive, etc.),

m. Anemia not responsive to iron therapy,

n. Drug addiction,

o. Vaginal bleeding or unusual abdominal pain.

52.5(3) *Late pregnancy.*

a. Third trimester uterine bleeding,

b. Toxemia of all classes,

c. Polyhydramnios or oligohydramnios,

d. Antepartum fetal death,

e. Thromboembolic disease,

f. Multiple pregnancy,

g. Need for fetal maturation studies,

h. Inappropriate fetal growth for gestational age (too small or too large),

i. Persistent abnormal presentation,

j. Postdate pregnancy of 42 weeks,

k. Rupture of membranes for more than 12 hours without labor, or evidence of amnionitis or sepsis at any time,

l. Premature labor (less than 36 weeks of gestation),

m. Induction of labor,

n. Tumor or other obstruction of birth canal,

o. Suspected feto-pelvic disproportion,

p. Clinical evidence of active herpes disease.

52.5(4) *Intrapartum.*

a. Inadequate progress in labor, suspected feto-pelvic disproportion or abnormal presentation,

b. Need for operative delivery,

c. Fetal distress suspected by abnormality of the fetal heart rate, fetal acidosis, or passage of meconium,

d. Fever or suspected amnionitis or sepsis,

e. Umbilical cord prolapse,

f. Any conditions listed in the previous subrule which appear first during labor,

g. Rh isoimmunization,

h. Identified fetal anomaly.

481—52.6(135G) Consultation. Each client shall have a consulting physician who currently has privileges to provide obstetrical services in a licensed hospital. The client shall be examined by the consulting physician at least twice during her pregnancy, at the time she enters care and during the third trimester.

52.6(1) The consulting physician shall sign an agreement with the birth center to provide advice and services.

52.6(2) The client shall have a consulting physician who currently has hospital pediatric privileges and who agrees to provide consultation and care for the newborn baby.

481—52.7(135G) Transfer to hospital. If complications arise during labor or birth or following birth, the mother or baby shall be transferred to a hospital for obstetrical or newborn care.

52.7(1) The birth center shall have a signed agreement with the participating hospitals stating that transferred mothers and babies will be accepted for admission if problems arise during labor, birth, or soon after birth. This agreement shall be reviewed and signed annually.

52.7(2) The birth center shall develop a written policy and procedure for arranging transfer to a hospital.

a. The birth center shall maintain a list of available neonatal and adult transportation services including ground and air ambulance services with the qualifications of each service and telephone numbers.

b. This list shall be posted near appropriate telephones.

c. These lists and the transfer protocols shall be reviewed and updated annually.

52.7(3) The birth center shall ensure that ambulance stretchers and wheelchairs will easily be able to enter and exit each birth room and the birth center by conducting a practice run with an ambulance service.

481—52.8(135G) Facility. All birth centers shall be designed, constructed, maintained, and operated to minimize the possibility of a fire or other life-threatening emergency to the staff and clients.

Hallways and doors providing entry and exit to the birth center and birth rooms shall be demonstrated to accommodate an ambulance stretcher.

An emergency power source shall be available that meets the fire marshal's requirements.

Written copies of a plan for evacuation in event of fire shall be available to all personnel. All personnel shall be instructed and kept informed of their responsibilities under the plan and supervised drills shall be conducted at least annually.

52.8(1) *Patient care areas.*

a. The family room shall include a play area for children and a living room setting of tables and chairs. It shall include some sleeping accommodation for use by family members.

b. The birth rooms shall be at least 120 square feet with at least 8-foot ceilings.

c. A sink with hot and cold running water with elbow-wrist controls shall be in or adjacent to each birth room.

d. Fixed or portable toilets shall be available to the mother in labor. A separate toilet shall be available for family and staff use.

e. Bath or shower facilities shall be available to the mother in labor.

f. Separate segregated storage areas shall be available for:

(1) Sterile supplies and equipment,

(2) Clean supplies and equipment,

(3) Janitorial supplies,

(4) Soiled supplies and equipment.

g. Storage and disposal of waste materials shall be in compliance with 481—subrule 51.7(34).

h. A utility area shall be available for washing, sterilizing and handling of equipment. Sterilization may be done off the premises.

i. An area with easy access to birth rooms or in birth rooms shall be designated for emergency equipment, medication, and supplies outlined in protocols for practice.

j. Consultation and examination rooms shall be large enough to hold an examination table, stool, handwashing facilities, writing desk, and chairs. Privacy and confidentiality shall be ensured.

52.8(2) *Office area.* When business offices are part of the birth center facility the office suite shall have a closed door between the office area and the patient care area. The area designated as the business area shall include:

a. A reception area which is large enough to allow clients to wait in comfort.

b. A support service area such as a library, record storage area, staff office, and laboratory.

52.8(3) *Equipment.*

a. Birth room furnishings shall be constructed of materials that are easily cleaned and maintained and shall include:

(1) A double bed or bed large enough to safely hold the mother and baby,

(2) Comfortable chair or chairs,

(3) Bedside and procedure table,

(4) A bassinet,

(5) Space for birth room supplies, equipment and family belongings.

b. The birth center may arrange for laundry to be done away from the birth center. If not, a washer and dryer shall be maintained in optimum working order. Clean linens shall be kept separated from soiled or contaminated linen.

c. Resuscitation equipment for both mother and infant.

(1) Infant. A table-like area of appropriate size and height shall be designated as an infant resuscitation area. This area shall have a radiant heat source fixed at the height recommended by the manufacturer. A resuscitation tray as described in protocols shall also be available in the area.

(2) Mother. Equipment for adult resuscitation as required by procedures outlined in protocols shall be maintained in an area convenient for emergency use.

d. Equipment needed to administer intravenous fluids shall be stored in an area convenient for emergency use.

e. A supply of oxygen shall be available for emergency use.

481—52.9(135G) Administration. A policy and procedure manual, adopted by the governing body, shall include all contracts and agreements of the birth center and shall be available for staff use and inspection by the department at all times. Policies and procedures shall also address provision of food for clients and their families, infection control, housekeeping, sanitation, disaster plans, medical record procedures, and criteria by which risk status will be established.

52.9(1) *Protocols for the management of routine and emergency care.* Protocols shall be developed by the director of medical affairs and the director or the director of midwifery services. They shall be available on site at all times. Annual review and revisions shall be documented.

a. Protocols shall address at least the following:

Provision of laboratory services,
Prenatal care,
Delivery care,
Emergencies with mothers,
Emergencies with infants,
Emergency transfers of mothers and infants,
Immediate postpartum care,
Newborn care,
Discharge criteria for the infant,
Discharge criteria for the mother,
Infection control.

b. Infection control protocols for handling of blood, body fluids, and body wastes shall be consistent with 1987 Center for Disease Control Guidelines published August 21, 1987, Vol. 36, No. 25 of Morbidity and Mortality Weekly Report available from U.S. Department of Health and Human Services, Public Health Services, Center for Disease Control, Atlanta, Georgia.

52.9(2) *Personnel policies.* Personnel policies shall include job descriptions for all personnel, employment agreements, description of required orientation, training and educational preparation. These policies shall be available on site.

52.9(3) *Management records.* The quality of the management of care of mothers, babies and families shall be evaluated by a review of records kept by staff of the birth center. A record of the following activities shall be included in the records, maintained on site, and made available for review by the department:

a. Regular staff meetings;

b. Case reviews, which must occur at least quarterly and must include all transfers and morbidity;

c. Midwifery audits conducted at least quarterly to evaluate the process and outcome of cases and client satisfaction;

d. Regular equipment maintenance; and

e. Drills for emergency procedures.

52.9(4) *Health records.* A health record shall list all services provided while the mother and fetus or newborn are under the care of the birth center. The record shall:

a. Be available at all times,

b. Include all reports of outside examinations or treatments and all related correspondence,

c. Be confidential and released only on the signature of the mother or, in the case of the baby, the signature of a parent or when the record is available by law according to Iowa Code section 135G.15(3)*"b,"*

d. Be made available to the department during licensure or complaint surveys,

e. Accompany, in copy form, the mother or newborn if either is transferred for other services,

f. Be stored in a secure manner and be readily retrievable,

g. Include:

(1) Identifying information,
(2) Risk assessments,
(3) Information relating to prenatal visits,
(4) Information relating to the course of labor and intrapartum care,
(5) Information relating to consultation, referral and transport to a hospital,
(6) Newborn assessment, Apgar score, record of required treatments and follow-up,
(7) Postpartum follow-up,
(8) Documentation of newborn metabolic testing as required by Iowa Code chapter 136A, and

h. Be reviewed and signed by the consulting physician after delivery.

52.9(5) *Administrative records.* The birth center shall maintain state inspection reports which shall be made available to any person. The person requesting the report may be required to pay a reasonable fee to cover copying costs. Inspection reports shall be maintained in the records of the birth center for five years.

52.9(6) *Birth and death reports.* Certificates of births, newborn deaths and stillbirths shall be reported as required by Iowa Code chapter 144.

52.9(7) *Annual report.* An annual report shall be submitted to the department which shall include:

1. Number of clients,
2. Number of births, deaths and referrals, and
3. Reasons for the deaths and referrals.

The content of the annual report may result in further review by the department to determine if violations are occurring.

481—52.10(135G) Services. Each client and family shall be fully informed of the policies and procedures of the licensed birth center, including, but not limited to:

1. The selection of clients,
2. The expectation for prenatal care and self-help involving the client and family,
3. The qualifications of the clinical staff,
4. Conditions which may result in a transfer to physician management or a hospital,
5. The philosophy of childbirth care practiced by the staff,
6. Services available, and
7. The customary length of stay after delivery.

52.10(1) *Informed consent.* No client shall be accepted for care at the birth center until she has signed a form indicating she has been informed of the possible risks and benefits of being enrolled in the birth center program for pregnancy and birth care. This form shall be developed by the department and used by the birth centers.

52.10(2) *Program of care.* The birth center shall provide at least:

a. A record of the personal, medical and family history,

b. A physical examination and laboratory tests,

c. A continuous assessment of risk to mother and baby,

d. Prenatal visits which comply with standards of the American College of Obstetricians and Gynecologists,

e. Prenatal education that includes the importance of nutrition; information on adverse effects of smoking, alcohol and other drugs; preparation for birth; breast feeding; and care of the newborn,

f. Intrapartum and postpartum services that foster parental control and responsibility in giving birth and bonding to the newborn,

g. Labor support for the client and her family,

h. Professional attendance at the birth, immediate postpartum care and newborn assessment, and

i. Surveillance and documentation of fetal heart rate and uterine contractions during labor.

52.10(3) *Other services.* Services not provided by the birth center and available in the community shall be made available to clients through referral.

52.10(4) *Emergency consultation, referral and transfer.* Emergency consultation or referral and transfer to obstetric and pediatric care or hospital obstetrical and newborn services shall be provided by the center when, in the course of pregnancy, labor or postpartum, risk factors are identified which may preclude continuation of care by the center.

a. Circumstances which shall require physician consultation and may require transfer of a client to a hospital include, but are not limited to:

(1) Inadequate progress in labor, suspected feto-pelvic disproportion or abnormal presentation,

(2) Need for operative delivery,

(3) Vaginal bleeding or unusual abdominal pain,
(4) Indications of fetal distress,
(5) Suspected amnionitis or sepsis,
(6) Suspected systemic infection,
(7) Umbilical cord prolapse, or
(8) Any condition listed in rule 52.4(135G) which first appeared during labor.

b. Circumstances which require transfer of a newborn to a hospital shall include:
(1) Less than 37 weeks gestation with a birth weight less than 2500 grams,
(2) Respiratory distress or cyanosis lasting longer than 15 minutes,
(3) Exposure to infection,
(4) Neonatal seizures,
(5) Suspected neonatal sepsis or meningitis,
(6) Congenital anomalies requiring diagnostic evaluation or neonatal surgery,
(7) Meconium aspiration,
(8) An Apgar score of six or less at five minutes,
(9) Apnea,
(10) Gastrointestinal distress as exemplified by bilious vomiting, continuous vomiting, abdominal distention, and bloody diarrhea,
(11) Suspected hypoglycemia documented by dextro stick or other similar method.

52.10(5) *Surgical procedures.* Surgical procedures shall be limited to those normally performed during uncomplicated childbirth, such as episiotomy and repair. Other surgical procedures such as forceps, tubal ligation, abortion, or Cesarean section shall not be performed in birth centers.

52.10(6) *Analgesia and anesthesia.* Pain control shall depend primarily on close human support, psychological analgesia and adequate preparation for the birth experience. Local anesthesia for pudendal block and episiotomy and repair may be administered according to procedures outlined in approved protocols.

52.10(7) *Chemical agents.* Labor may not be stimulated or augmented with chemical agents. Labor may be inhibited with chemical agents only when prescribed by a physician in anticipation of an emergency transfer.

52.10(8) *Discharge follow-up.* A mother and her infant shall be dismissed within 24 hours after the birth of the infant. If a mother or infant is retained at the birth center for more than 24 hours after the birth, a report shall be filed with the department within 48 hours of the birth describing the circumstances and the reasons for the decisions.

a. A prophylactic shall be instilled in the eyes of each newborn in accordance with Iowa Code section 140.13.

b. Postpartum evaluation and follow-up care shall be provided, which shall include:
(1) A physical examination of the infant,
(2) Metabolic screening tests required by Iowa Code chapter 136A,
(3) Referral to sources for pediatric care,
(4) Maternal postpartum assessment,
(5) Instruction in child care, including immunizations,
(6) Family planning services, and
(7) Referral to a licensed hospital.

481—52.11(135G) Evaluation. The birth center shall have available on-site reports of periodic self-evaluation of the service that shall include, but not be limited to:
1. Demonstration of how program goals and objectives are being met;
2. Analysis of data collected on use of services and outcomes for mothers and babies;
3. Determination of client satisfaction.

These rules are intended to implement Iowa Code chapter 135G.

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CHAPTER 53
HOSPICE LICENSE STANDARDS

481—53.1(135J) Definitions. The use of the word "shall" indicates mandatory standards. The definitions set out in Iowa Code section 135J.1 shall be considered to be incorporated verbatim in the rules. As used in this chapter:

"Bereavement service" is support offered during the bereavement period to the family and friends of someone who has died.

"Care setting" means the place in which care is being given, for example, patient's home, a hospital, a care facility or another place of residence.

"Family" means the immediate kin of the patient, including a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, child, or stepchild. Additional relatives or individuals with significant personal ties to the hospice patient may be included in the hospice patient's family.

"Home care provider" means a care agency that contracts with the hospice to provide services in the home of the hospice patient. The providers may include, but are not limited to, home health aides, homemakers, nurses, occupational therapists or physical therapists.

"Primary caregiver" means the person with major responsibility for providing care to a hospice patient.

"Protocols" are defined as written sets of directions to be followed in performing procedures. These may be routine or may describe specific actions staff must follow when particular events occur.

"Psychosocial needs" involve a person's mental and emotional life related to behavior to other people.

"Social services" are services provided by someone who has a bachelor's or higher degree in social work.

"Spiritual counselor" may be clergy, a hospice employee, a volunteer or someone chosen by the patient.

"Utilization review" means a program to assess the kind of care delivered and to identify needs which may not have been met.

481—53.2(135J) License. Application for an initial or renewal license may be obtained from the Department of Inspections and Appeals, Division of Health Facilities, Lucas State Office Building, Des Moines, Iowa 50319.

53.2(1) Prior to the issuance of a license each hospice must meet all the requirements set forth in this chapter.

53.2(2) The applicant shall submit a nonrefundable biennial license fee of $500. If a license lapses for failure to make timely application for renewal, an additional 25 percent is required.

53.2(3) Each hospice seeking licensure is surveyed before the initial license is issued and biennially before a license is renewed.

53.2(4) Home care provider and inpatient facilities used by the hospice shall be inspected by the department to determine whether hospice regulations are met.

53.2(5) Hospices certified as Medicare providers by the department or accredited by the Joint Commission on the Accreditation of Health Organizations will be licensed without inspection.

53.2(6) The department may not prohibit any entity from establishing or maintaining a hospice without a license.

53.2(7) The department may deny, suspend or revoke a license if the department finds that a hospice does not comply with these rules.

53.2(8) A license is issued only for the premises, person, hospital or facility named on the application. The license may not be transferred or assigned to another person or entity.

53.2(9) A license expires two years after the date issued unless it is suspended or revoked before that date.

This rule is intended to implement Iowa Code sections 135J.2 and 135J.4 to 135J.6.

481—53.3(135J) Patient rights. Each hospice program shall have written policies and procedures that support, enhance and protect the human, civil, constitutional and statutory rights of all patients.

53.3(1) Patient rights include, but are not limited to, the right to:

a. Be treated with dignity and respect;

b. Be informed of the type of care and the services provided by the hospice program;

c. Information regarding diagnosis and prognosis and any change in either;

d. Review and participate in their plan of care; and

e. Privacy.

53.3(2) A copy of these rights shall be provided to all individuals admitted to a hospice.

This rule is intended to implement Iowa Code section 135J.3(3).

481—53.4(135J) Governing body. The hospice shall have a local governing body which consists of people who represent the geographic area for which the hospice intends to provide service.

53.4(1) The governing body shall:

a. Develop a written mission statement, goals and objectives for the hospice and meet with sufficient regularity to ensure accomplishment of those goals and objectives;

b. Develop, amend and implement bylaws;

c. Assume responsibility for the total operation of the hospice;

d. Appoint an administrator whose qualifications and duties are defined in writing and who has authority to manage the business affairs and to direct all programs of the hospice;

e. Develop the budget and monitor the fiscal affairs of the hospice;

f. Provide for medical direction by a licensed physician;

g. Provide appropriate, qualified personnel in sufficient quantity to ensure availability of hospice services listed below, 24 hours a day, seven days a week;

h. Develop and implement written policies and procedures relating to:

(1) Admission and discharge criteria,

(2) Response to referrals,

(3) Medical direction,

(4) Physician services,

(5) Nursing services,

(6) Nutritional services,

(7) Pharmacy services,

(8) Social services,

(9) Volunteer services,

(10) Spiritual services,

(11) Patient and family education,

(12) Bereavement services,

(13) Staff response to death at home and in institutions,

(14) Coordination and communication between all agencies serving the patient and family,

(15) Communication with community agencies, and

(16) Community education efforts;

i. Develop and implement written personnel policies; and

j. Develop and implement a written plan for review of the services delivered.

53.4(2) The governing body shall ensure that someone is responsible to:

a. Organize and direct the ongoing functions of the hospice program;

b. Meet the requirements of the written job descriptions;

c. Maintain liaison with the governing body and staff to ensure administrative control and professional supervision over all patient and family services furnished;

d. Provide orientation and in-service training for all staff which covers the physical, emotional, spiritual and social needs of hospice patients and their families during the final stages of illness, at death and during grief;

e. Plan, organize, implement, guide and evaluate the program;

f. Formulate and conduct a review of policies and procedures, including quality assurance; and

g. Ensure that all required reports and records are completed, submitted and maintained. This includes personnel, administrative and clinical records.

This rule is intended to implement Iowa Code section 135J.3.

481—53.5(135J) Quality assurance and utilization review. The hospice must have a written procedure for individual assessment of care provided, a process for identifying problems and a system to report findings and recommendations for improving the quality of care delivered to the governing body.

53.5(1) At least quarterly, the medical director, patient coordinator and social worker used by the hospice program shall review a minimum of a 10 percent sample of combined active and inactive clinical records of care delivered to hospice patients and families. A written summary shall be prepared for each individual assessment, commenting on the amount and kind of care delivered and including statements addressing any unmet needs.

53.5(2) At least quarterly, all summaries of individual assessments shall be reviewed by the people responsible for coordinating quality assurance. A written report will be prepared addressing any identified problems with care, treatment services, availability of services and methods of care delivery.

53.5(3) The quality assurance reports shall be made available to the hospice administrator and governing body. The reports shall be reviewed by the governing body at least annually, and the review recorded in the governing body's meeting minutes.

This rule is intended to implement Iowa Code section 135J.3(8).

481—53.6(135J) Attending physician services. The patient or family shall designate an attending physician who is responsible for managing necessary medical care. The attending physician shall:

1. Have an active Iowa license to practice medicine pursuant to Iowa Code chapter 148, 150 or 150A;
2. Certify in conjunction with the medical director that each person requesting admittance is eligible as required by Iowa Code section 135J.1(3) for hospice care;
3. Be responsible for the medical component of the plan of care;
4. Participate in developing and revising the plan of care;
5. Arrange for continuity of the medical management in the attending physician's absence; and
6. Monitor the condition of the patient and family by direct contact, or communication with the interdisciplinary team (IDT) and others.

This rule is intended to implement Iowa Code section 135J.3(4).

481—53.7(135J) Medical director. Each hospice shall have a medical director who is a physician licensed to practice medicine pursuant to Iowa Code chapter 148, 150 or 150A. The medical director shall:

1. Be a member of the interdisciplinary team;
2. Monitor the quality of care provided;
3. Assist in providing assurance of the quality of care provided to the patient and family;
4. Maintain liaison with the attending physician;
5. Review clinical material from the patient's attending physician to certify the prognosis as anticipated by that physician;
6. Participate in providing direction for the medical component of care;
7. Participate in resolving conflicts regarding care to be provided;
8. Name a qualified physician to be available in the medical director's absence; and
9. Participate in the development and review of patient and family care policies, procedures and protocols.

This rule is intended to implement Iowa Code section 135J.3(1).

481—53.8(135J) Interdisciplinary team (IDT). The IDT shall establish a plan of care for each patient and family based on assessments performed by team members.

53.8(1) The interdisciplinary team shall include the:

a. Patient;
b. Hospice patient's family;
c. Attending physician;
d. Medical director;
e. Patient care coordinator;
f. Staff nurse;
g. Social worker;
h. Coordinator of volunteer service; and may include
i. A spiritual counselor and others deemed appropriate by the hospice.

53.8(2) Prior to or on the day of admission, the attending physician and at least one IDT team member shall develop an initial plan based on a preliminary assessment of the patient and family needs.

53.8(3) Within seven calendar days of admission the interdisciplinary team shall assess the needs of the patient and family. A care plan shall be based on these findings.

53.8(4) Within seven calendar days of admission the interdisciplinary team shall meet to develop a comprehensive written plan of care. The plan of care shall:

a. Identify the primary caregiver or an alternate arrangement for care;
b. List the needs of the patient and family;
c. List any intervention planned to meet the needs of the patient and family and the results expected from each intervention;
d. Indicate which team member(s) is responsible for each intervention;
e. Indicate the anticipated frequency of each intervention; and
f. Indicate the prognosis and expected disease process.

53.8(5) The IDT shall monitor and revise the plan of care on a regular basis. The team shall meet weekly and exchange information regarding the needs of the patient and family. Changes in the care plan shall be made when the needs of the patient or family change or when interventions do not result in the expected or intended response.

This rule is intended to implement Iowa Code section 135J.3(5).

481—53.9(135J) Nursing services. Nursing services shall be planned and provided or supervised by a registered nurse who has a current Iowa license to practice nursing. The service shall be available 24 hours a day, seven days a week.

53.9(1) A registered nurse shall assess patient and family nursing needs and develop a nursing plan of care to meet these needs.

53.9(2) The nursing service staff shall:

a. Participate in IDT meetings to develop and amend the plan of care;
b. Provide nursing service in accordance with the overall plan of care developed by the IDT;
c. Consult with the patient and family regarding how to meet nursing and nursing-related needs of the patient;
d. Document nursing care given and observations made regarding patient, family reactions and status;
e. Consult with other care providers and the family to enhance continuity of care;
f. Develop and implement nursing service objectives, policies and procedures;
g. Develop job descriptions for all nursing personnel;
h. Establish staff schedules to meet patient and family needs and ensure 24-hour service;
i. Develop and implement orientation and training programs;
j. Develop and implement performance evaluation for the nursing staff;
k. Assign duties to nurses consistent with their education and experience; and
l. Facilitate periodic meetings of the professional nursing staff to evaluate the nursing care provided by hospice personnel.

53.9(3) Persons who are employed by, volunteer with or work under contract to a licensed hospice organization may administer medications only if they are also a licensed nurse, a licensed physician or a certified medication aide.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.10 Reserved.

481—53.11(135J) Coordinator of patient care. A registered nurse, social worker or health care administrator shall be designated to coordinate implementation of the plan of care for each patient.

The coordinator of patient care shall at least:

1. Coordinate all aspects of patient care to ensure continuity, including care by all service disciplines in all care settings;
2. Facilitate exchange of information among all personnel who provide services to ensure complementary efforts and support for objectives outlined in the plan of care;
3. Facilitate communication between caregivers, patient and family;
4. Maintain a roster of patients;
5. Maintain a schedule for IDT review of care plans; and
6. Chair IDT conferences.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.12(135J) Social services. Social services shall be planned and provided or supervised by a person who has at least a bachelor's degree in social work from a school approved by the council on social work education. The social worker shall at least:

1. Consider the emotions and social support system of the patient and family;
2. Assess the ability of the family and the patient to function socially and to deal with their emotions;
3. Identify patient and family social service needs;
4. Participate on the IDT to develop and amend the plan of care;
5. Provide services in accordance with the plans of care developed by the IDT;
6. Document services provided and observations made regarding patient and family response and status; and
7. Cooperate and communicate with other providers and the family to enhance the continuity of care.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.13(135J) Counseling services. Counseling is the process of helping people adjust to the grief of illness, dying and loss. Counseling shall be provided in accordance with the plan of care. When the interdisciplinary team identifies the need for additional counseling services, a team member shall be designated to make an appropriate referral. No referrals may be made without the agreement of the patient and the family.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.14(135J) Volunteer services. Each hospice shall provide volunteer services to meet patient and family needs. A coordinator of volunteer services shall be designated to implement written policies and procedures.

53.14(1) Each volunteer shall have at least 14 hours of education provided by the hospice before being assigned to a patient and family. The following topics shall be included in the educational program:

a. Hospice concept and philosophy;
b. Symptom control;
c. Infection control;

d. Home care skills;
e. Safety measures and transfer techniques;
f. Stress management;
g. Communication needs;
h. Psychosocial needs;
i. Spiritual needs;
j. Death, dying and grief; and
k. Funerals and alternative rituals.

53.14(2) The hospice shall offer at least two hours of in-service training each quarter.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.15(135J) Spiritual counseling. Spiritual counseling shall be available to all patients and their families.

53.15(1) Spiritual counseling shall:
a. Be based on the beliefs and values of the patient and family; and
b. Be provided in accordance with the interdisciplinary plan of care.

53.15(2) If spiritual counseling is provided through a working relationship with clergy or other spiritual counselors in the community, there shall be ongoing communication between that counselor and the interdisciplinary care team.

53.15(3) There shall be written and implemented policies and procedures regarding spiritual counseling.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.16(135J) Optional services. Optional services are services provided by the hospice which are not required. Examples are home health aide, therapy and respite. The following apply to the provision of all optional services provided by a hospice:

53.16(1) All service providers shall be oriented to the hospice concept and philosophy.

53.16(2) All services shall be provided in accordance with the interdisciplinary plan of care.

53.16(3) Written and implemented policies and procedures shall:
a. Identify service providers;
b. Identify the person who will supervise the provision of services;
c. Require documentation of services provided and patient and family response; and
d. Describe a mechanism for evaluating quality of care provided.

This rule is intended to implement Iowa Code section 135J.1(7).

481—53.17(135J) Contracted services. A hospice may contract with other health care providers for the provision of all services.

53.17(1) Contracts shall be written and clearly delineate the authority and responsibility of each party to the contract.

53.17(2) The hospice shall maintain responsibility for coordinating and administering the hospice program.

53.17(3) Contracting for a service does not absolve the hospice of legal responsibility for provision of that service.

53.17(4) The hospice shall inform the patient whether the hospice is paying for the contracted services.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.18(135J) Short-term hospital services. Each hospice shall have a written agreement with a local or area hospital which promotes continuation of the hospice plan of care and training for hospital staff who care for hospice patients.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.19(135J) Bereavement services. Bereavement services shall be available to each family after the death of a patient and shall be provided in accordance with family needs.

53.19(1) Bereavement services shall include:

a. Exchange of information between people who provide bereavement services and team members who provided care before death;

b. Consideration of the family's situation, including risk factors, used to develop a plan for services;

c. Identification of types of help or intervention to be available and provided;

d. Contact with the family after the death as required by their needs as documented in the plan of care; and

e. A process to assess family reactions and hospice referrals for intervention deemed appropriate by the IDT.

53.19(2) There shall be written and implemented policies and procedures governing the delivery of bereavement services.

This rule is intended to implement Iowa Code section 135J.3(6).

481—53.20(135J) Records. In accordance with accepted principles of medical record practice, each hospice shall maintain a centralized complete record on every individual receiving services. This record shall be preserved for at least three years following termination of services.

53.20(1) Each entry shall be dated and signed, including the name and title of the person who makes the entry.

53.20(2) The record shall include documentation of all services provided, whether furnished by the hospice or by contractual agreement. Each record shall include, but not be limited to:

a. Patient identification and demographic data;

b. Initial and subsequent assessments;

c. The plan of care;

d. Medical history;

e. Documentation of all services provided;

f. Consent and authorization forms;

g. Physicians' orders;

h. Medication records;

i. Discharge summary; and

j. Discharge and transfer records.

53.20(3) The hospice shall have written and implemented policies to safeguard destruction or unauthorized use of patient records. Written procedures shall govern use and removal of records, conditions for release of information and identification by title of the person who may release records.

These rules are intended to implement Iowa Code sections 135J.1 to 135J.6.

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CHAPTER 54
QUALITY AWARD FOR HEALTH CARE FACILITIES

481—54.1(135C) Purpose. This program is intended to recognize quality health care services being provided to facility residents by Iowa long-term care facilities, residential care facilities, and intermediate care facilities for the mentally retarded or persons with mental illness. The specific objective of the program is to establish a governor's award for quality care to recognize health care facilities in the state which demonstrate provision of the highest quality care to residents.

481—54.2(135C) Definitions.

"Advisory council" means the council appointed by the director to review all nominations received by the department. Members of the council shall include the director, or the director's designee, and members selected to represent the general public, health care providers, resident advocates, the long-term care ombudsman's office, residents, and other groups as deemed necessary by the director. When making appointments to the advisory council, the director may consult with the Iowa Partners for Resident Care or other groups representing the nursing home associations and resident advocates that oversee operation of a facility or group of facilities. No member of the advisory council shall be a provider of services to a facility or under contract to provide services to a facility.

"Community living training services" means those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person's maximum potential in the physical and social environment.

"Department" means the department of inspections and appeals.

"Director" means the director of the department of inspections and appeals, or the director's designee.

"Health care facility" or *"facility"* means a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with mental retardation.

"Nursing care" means those services which can be provided only under the direction of a registered nurse or a licensed practical nurse.

"Nursing facility" means an institution or a distinct part of an institution housing three or more individuals not related to the administrator or owner within the third degree of consanguinity, which is primarily engaged in providing health-related care and services including, but not limited to, rehabilitative services, personal care, or community living training services for a period exceeding 24 consecutive hours for individuals who, because of a mental or physical condition, require nursing care and other services in addition to room and board.

"Personal care" means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

"Rehabilitative services" means services to encourage and assist restoration of optimum mental and physical capabilities of the individual resident of a health care facility.

"Resident" means an individual admitted to a health care facility in the manner prescribed by Iowa Code section 135C.23.

"Social services" means services relating to the psychological and social needs of the individual in adjusting to living in a health care facility, and minimizing stress arising from that circumstance.

481—54.3(135C) Nomination. The director will prepare and make available a nomination application no later than June 30 of each year.

481—54.4(135C) Deadline for submission of nominations. Nominations will be taken during the first quarter of each fiscal year. The deadline for receipt of nominations is September 30 of each year.

481—54.5(135C) Applicant eligibility. Eligible nominations shall be made by a resident, family member of a resident, member of a resident advocacy committee, or another health care facility. A health care facility cannot nominate itself for the award; however, this prohibition shall not apply to facilities with common ownership. Only health care facilities licensed pursuant to Iowa Code chapter 135C shall be eligible for nomination.

481—54.6(135C) Administration. The quality awards program shall be administered by the director or the director's designee.

481—54.7(135C) Priority. All nominations submitted to the department and received on or before the deadline for receipt of nominations shall be given consideration.

481—54.8(135C) Nomination. Applications for the governor's quality award shall include but not be limited to the following information:

54.8(1) The reasons that the nominated facility should be considered.

54.8(2) Any unique or special care or services provided by the facility to its residents. Care or services include any unique or special nursing care, personal care, rehabilitative services, social services, or community living training services provided by the facility for its residents, or involvement with the local community.

54.8(3) Activities conducted by the facility to enhance the highest quality of life for its residents.

481—54.9(135C) Evaluation. The director shall appoint an advisory council to review all nominations received by the department. The members shall review all nominations and select finalists based upon the material(s) provided in the nomination forms. The council shall also consider the following factors in making its selections:

54.9(1) The facility report card completed pursuant to Iowa Code section 135C.20A.

54.9(2) Any unique services provided by a facility to its residents to improve the quality of care in the facility.

54.9(3) Any information submitted by resident advocacy committee members, residents, a resident's family members, or facility staff with regard to the quality of care provided by the facility to its residents.

54.9(4) Whether the facility accepts residents for whom costs are paid under Iowa Code chapter 249A.

481—54.10(135C) Selection of finalists. When reviewing the nominations, the advisory committee shall rank all facilities according to the above criteria. The ranked list of facilities shall be provided to the director for further review and consideration. When making the final selection, no more than two facilities from each congressional district shall be recognized as an award winner.

481—54.11(135C) Awarding of certificate. Prior to the final selection of facilities, representatives from the department and the governor's office will tour all finalists to determine the winners. The department will select the winners of the governor's quality award from the facilities recommended by the advisory council. The winners will receive a framed certificate in recognition of their designation as a quality health care provider of the year. The certificate shall be awarded by the governor or the governor's designee to the facility administrator in a recognition ceremony held at the facility's place of business.

These rules are intended to implement Iowa Code Supplement section 135C.20B.

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CHAPTER 55
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[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

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17.14(461A) Permit and lease revocation
17.15(461A) Severability

571—15.9(483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors.

15.9(1) *Purpose.* Pursuant to Iowa Code sections 321G.23(2), 462A.1 and 483A.27(4), the department will certify volunteer instructors to teach bow, fur harvester, snowmobile, ATV, boating and hunter education courses.

15.9(2) *Definitions.* For the purpose of this rule:

"Certified instructor" means a person who has met all criteria in this rule for one or more of the above-named courses.

"Course" means the department's bow, fur harvester, snowmobile, ATV, boating and hunter education and ethics courses.

"Department" means the Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319-0034.

"Instructor applicant" means a person who has applied to become a certified volunteer instructor for one of the above-named courses.

15.9(3) *Minimum qualifications.* The following conditions must be satisfied before any person can become a certified instructor. Failure to meet these conditions will result in the denial of the application. An applicant may be disqualified if the applicant has accumulated any habitual offender points pursuant to rule 571—15.6(481A), or other license suspension by the court or department. The instructor applicant will be notified of the denial by the recreational safety coordinator. An instructor applicant shall:

a. Submit an application as provided by the department to the local conservation officer or recreational safety officer.

b. Be at least 18 years of age.

c. Have experience in handling equipment, such as firearms, bows and arrows, furbearer traps, snowmobiles, ATVs and various navigational vessels, that is necessary for the various prescribed courses.

d. Have completed the course as defined in subrule 15.9(2).

e. Attend and pass an instructor's training and certification course administered by the department.

f. Submit to a background check. This check will include, but not be limited to, a criminal history check as provided by the department of public safety. A record of a felony conviction will disqualify the applicant. A record of serious or aggravated misdemeanors may disqualify the applicant based on type of offense and year committed.

g. Successfully complete the apprenticeship as required in subrule 15.9(4).

15.9(4) *Instructor applicant apprenticeship.* In addition to subrule 15.9(3), the following conditions must be satisfied to complete the instructor applicant apprenticeship:

a. Participate in one course.

b. Apprentice with a certified instructor.

The recreational safety officer may make the determination as to which certified instructor will be supervising the instructor applicant during the apprenticeship.

15.9(5) *Certified education instructor responsibilities.* A certified instructor has the following responsibilities:

a. To complete all prerequisites to becoming an instructor as provided in subrules 15.9(3) and 15.9(4).

b. To follow all policies and procedures as set forth in the current "Instructor Procedures Manual."

c. To assist in the recruitment and training of additional volunteer instructors.

d. To recruit and train students in the applied-for prescribed course program.

e. To actively promote the program in the instructor's county and to arrange for publicity for each new class.

f. To maintain order and discipline in the classroom and outdoor classroom at all times.

g. To accurately fill out required forms and reports for each class and mail that material to the recreational safety coordinator within 15 days after completion of the course.

h. To teach the course as prescribed by the department.

i. To maintain a file on all students that the instructor teaches.

j. To actively participate in one course every two years. If this requirement is not met, the instructor's certification may be terminated after notification by letter by the recreational safety coordinator. The person may reapply to become a volunteer safety education instructor pursuant to subrule 15.9(3).

k. To attend a minimum of one continuing education instructor workshop every three years for hunter education as provided by the department.

15.9(6) *Grounds for revocation of instructor certification.* The department may, at any time, seek to revoke the instructor certification of any person who:

a. Fails to meet the instructor responsibilities as outlined in subrules 15.9(4) and 15.9(5).

b. Fails to follow the policies and procedures as set forth in the current "Instructor Procedures Manual."

c. Falsifies any information as may be required by the department.

d. Handles any equipment in an unsafe manner, or allows any student or other instructor to handle equipment in a reckless or unsafe manner.

e. Is convicted of or forfeits bond for any fish and game, snowmobile, ATV or navigation violation of this state or any other state.

f. Uses abusive or foul language while conducting a course.

g. Participates in a course while under the influence of alcohol or any illegal drug.

h. Has substantiated complaints filed against the instructor by the public, department personnel or other certified instructor(s).

i. Fails to meet the requirements in subrule 15.9(5), paragraphs *"j"* and *"k."*

j. Is convicted of a felony or an aggravated or serious misdemeanor as defined in the statutes of this state. This would also include any felonies or comparable misdemeanors of any other state.

k. Receives compensation directly or indirectly from students for time spent preparing for or participating in a course.

15.9(7) *Termination of certification.* Any certified instructor has the right, at any time, to voluntarily terminate certification. If an instructor voluntarily terminates certification or certification is terminated by the department, the instructor must return to the department the certification card and all materials that were provided.

15.9(8) *Compensation for instructors.* Instructor applicants and certified instructors shall not receive any compensation for their time either directly or indirectly from students while preparing for or participating in a course. However, instructor applicants and certified instructors may require students to pay for actual course-related expenses involving facilities, meals or materials other than those provided by the department.

15.9(9) *Hearing rights.* If the department seeks to revoke an instructor certification pursuant to subrule 15.9(6), the department shall provide written notice of intent to revoke the certification as provided in 561—7.16(17A,455A). If the certified instructor requests a hearing, it shall be conducted in accordance with 561—Chapter 7.

This rule is intended to implement Iowa Code sections 321G.23(2), 462A.1 and 483A.27.

571—15.10(483A) Transportation tags for military personnel on leave from active duty.

15.10(1) *Military transportation tags for deer and turkey.* The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

15.10(2) *Annual limit for military transportation tags.* A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

15.10(3) *Regulations apply to military personnel.* With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

This rule is intended to implement Iowa Code section 483A.24.

571—15.11(483A) Refunds or changes for special deer and turkey permits and general licenses.

15.11(1) *Invalid applications.* Deer and turkey permit applications that are received too late for processing after the closing date for acceptance of applications or applications that are invalid on their face will be returned unopened to the applicant. Permit fees related to applications which are determined to be invalid by a computer analysis or other analysis after the applications have been processed will be refunded to the applicant, less a $10 invalid application fee to compensate for the additional processing cost related to an invalid application.

15.11(2) *Death of applicant.* Deer or turkey permit fees will be refunded to the applicant's estate when the permittee's death predates the season for which the permit was issued and a written request is received from the permittee's spouse, executor or estate administrator within 90 days of the last date for which the permit was issued.

15.11(3) *National or state emergency.* Deer or turkey permit fees will be refunded if the permittee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the permit was issued. A written refund request must be received by the DNR within 90 days of the last date of the season for which the permit was issued.

15.11(4) *Permit changes.* The agency will attempt to change an applicant's choice of season or type of permit if a written or telephonic request is received by the license bureau in sufficient time, usually 20 days, prior to printing the permit, and if the requested change does not result in disadvantage to another applicant. Telephonic change requests must be verified in writing by the requester before a change request will be honored. The agency's ability to accommodate requests to change season or permit type is dependent on workload and processing considerations. If the agency cannot accommodate a request to change a season or type choice, the permit will be issued as originally requested by the applicant. No refund will be allowed. The agency will not change the name on the permit from that submitted on the application.

15.11(5) *General hunting and fishing licenses duplicate purchase.* Upon a showing of sufficient documentation, usually a photocopy of the licenses, that more than one hunting or fishing license was purchased by or for a single person, the agency will refund the amount related to the duplicate purchase. A written refund request, with supporting documentation, must be received by the license bureau within 90 days of the date on the face of the duplicate licenses.

15.11(6) *Other refund requests.* Except as previously described, the agency will not issue refunds for any licenses, stamps or permits related to fishing and hunting.

This rule is intended to implement Iowa Code section 483A.24.

These rules are intended to implement Iowa Code sections 321.23(2), 481A.38 and 481A.134 and Iowa Code chapter 483A.

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CHAPTER 16
PUBLIC, COMMERCIAL, PRIVATE DOCKS AND DOCK MANAGEMENT AREAS
[Prior to 12/31/86, Conservation Commission[290] Ch 33]

571—16.1(461A) Definitions. For the purpose of this rule, the following terms are used:

"All docks" means private docks, public docks, commercial docks, and docks constructed in dock management areas.

"Catwalk" means a walkway constructed for access from the dock to moored vessels or boat storage structures.

"Commercial dock" means any dock on or over waters under the jurisdiction of the commission in which the use or operation of the dock involves a fee, directly or indirectly.

"Commission" means the natural resource commission.

"Department" means the department of natural resources.

"Director" shall mean the director of the department of natural resources.

"Dock management area" means those areas adjacent to publicly owned riparian land or a specially developed harbor area, either of which has been designated a dock management area by the department of natural resources.

"General permit" means a permit issued as a rule of this chapter to authorize maintenance of an eligible class of private docks. The owner of a private dock that is eligible for coverage under a general permit need not file an individual dock permit application. Unless otherwise specified, a general permit is valid for five years.

"Lakes" includes all natural lakes and artificial lakes to which the public has lawful access from land or from a navigable stream inlet, excepting river impoundments as defined in this rule.

"Private dock" means a dock extending from the private property of a riparian landowner and constructed on or over waters under the jurisdiction of the natural resource commission and which is not used as a marina or for other commercial purposes or made available for public use.

"Public dock" means a dock over waters under the jurisdiction of the commission extending from riparian public land or from private land to which the public has been granted a license to travel and either of which is open to public use.

"River impoundments" means all pools upstream from dams on meandered and nonmeandered rivers. Examples are Lake Panorama, Lake Delhi and Lake Nashua.

571—16.2(461A) When dock permit required. No person shall construct a private dock, public dock, or commercial dock on a lake, river, or river impoundment without first obtaining a permit from the department. Individual permits must be obtained for all public and commercial docks. Individual permits must be obtained for all private docks which do not conform to the general permit criteria in 571—16.3(461A) or 16.4(461A).

571—16.3(461A) General permit for certain private docks on lakes. This rule constitutes a general permit for certain private docks on lakes as defined in 571—16.1(461A). This general permit expires March 1, 2005. This general permit authorizes maintenance of private docks conforming to the standard conditions set forth in 571—16.5(461A) and the following additional criteria:

16.3(1) *Spacing and alignment.* The dock shall be offset at least 25 feet from the nearest adjoining property boundary and at least 50 feet from the nearest other lawful dock. If these offsets are impossible due to the narrowness of the riparian parcel, the dock shall be located to conform as nearly as reasonably possible to these minimum offsets. The dock must be aligned so as not to cross the projection of the adjoining property line into the lake.

16.3(2) *Dimensions.* The width shall be not less than 3 nor more than 6 feet. The total length of the dock shall not exceed 100 feet measured from the ordinary high water line of the lake as determined by the department. However, the director may authorize a temporary extension of length as reasonably needed during low lake levels.

16.3(3) *Configuration.* Docks offset at least 25 feet from the nearest adjoining property boundary will be allowed one segment which is at an angle to the dock. This segment and the dock must be offset at least 50 feet from any lawful dock. This segment shall not be longer than 16 feet, measured along its angle to the dock and including the width of the dock, and shall not create a platform larger that 168 square feet. If the segment is less than 25 feet from the nearest adjoining property boundary or less than 50 feet from the nearest lawful dock, it may not be longer than 8 feet, measured along its angle to the dock and including the width of the dock, and shall not create a platform larger than 80 square feet. These segments may not be less than 30 feet from another lawful dock.

16.3(4) *Hoists and other adjacent structures.* A hoist or other boat storage structure shall not be placed adjacent to any segment more than 6 feet wide.

571—16.4(461A) General permit for certain private docks on rivers and river impoundments. This rule constitutes a general permit for certain private docks on rivers and river impoundments as defined in 571—16.1(461A). This general permit expires March 1, 1999. This general permit authorizes maintenance of private docks conforming to the standard conditions set forth in 571—16.5(461A) and the following additional criteria:

16.4(1) *Spacing and alignment.* The dock shall be offset at least 25 feet from the nearest adjoining property boundary and at least 50 feet from the nearest other lawful dock. If these offsets are impossible due to the narrowness of the riparian parcel, the dock shall be located to conform as nearly as reasonably possible to these minimum offsets. The dock must be aligned so as not to cross the projection of the adjoining property line into the river or river impoundment.

16.4(2) *Dimensions.* The width shall be not less than 3 nor more than 6 feet. The total length of the dock shall not exceed the lesser of 50 feet or one-fourth of the width of the waterway measured from the water's edge at normal river stage.

16.4(3) *Configuration.* Docks on rivers and river impoundments will be allowed segments which are at an angle to the dock. These segments may not exceed 25 feet in length, measured along their angle to the dock, and these segments must be at least 3 feet wide and may not exceed 6 feet in width. There may be two of these segments on one side of the dock, but not one on each side of the dock if the result would cause the frontage to exceed 25 feet.

16.4(4) *Hoists and other adjacent structures.* A hoist or other boat storage structure shall not be placed upstream or downstream from any dock segment more than 6 feet wide.

16.4(5) *Anchoring.* All river docks must be securely anchored to prevent them from becoming floating hazards during times of high river flows.

571—16.10(461A) Fees for commercial docks, docks in dock management areas and private docks requiring an individual permit.

16.10(1) *Enclosed docks.* Any dock constructed with one or more sides enclosed will be subject to the following fee schedule in addition to that specified for docks in dock management areas.

1. Up to 15 feet wide and not more than 20 feet long—$50 annually.
2. Over 15 feet wide and not more than 20 feet wide and not more than 24 feet long—$75 annually.
3. Over 20 feet wide and not more than 28 feet long—$100 annually.
4. Over 25 feet wide shall be proportionate to the above width fees.

16.10(2) *Fees for commercial docks.* A fee shall be assessed for each commercial dock not within a dock management area which provides slips for boats other than those owned by the applicant and used to carry on commerce under riparian rights. The fee shall be $2 per slip to accommodate boats under 26 feet and $4 per slip for those to accommodate boats over 26 feet.

16.10(3) *Fees for docks in dock management areas.* In each dock management area, the department of natural resources shall evaluate the benefits to the dock applicant and establish a dock permit and hoist or mooring fee based on the following criteria:

1. The desirability of the water;
2. The placement of the dock and area on the water;
3. The public benefit or inconvenience;
4. The private benefit;
5. Comparable docking fees.

16.10(4) *Fees for private docks.* A fee of $25 per year shall be assessed on private docks requiring an individual permit. The fees shall be paid, upon application, for the requested term of the permit.

16.10(5) *Payment of fees.* Payment of the annual fee for commercial docks, docks in dock management areas, and private docks requiring an individual permit shall be made upon application and may be paid in a lump sum in advance for the term of the permit. Permits issued under the rule for which the annual fee has not been paid by April 1 of any year are void but may be reinstated by payment of all fees due for the year reinstatement is sought, as well as any prior years in the term of the permit for which an annual fee has not been paid. Payment of any fee under this rule shall be made to the department of natural resources.

571—16.11(461A) Liability. Neither the department of natural resources nor the state of Iowa will be responsible for any injury to persons or damage to property arising out of or incidental to the construction, use, or storage of any dock for which the department of natural resources has issued a permit, howsoever the injury or damage may be caused. The permittee, and if the riparian owner is not the permittee, the riparian owner as well shall indemnify and save the department of natural resources and the state of Iowa harmless from any and all claims for any injury or damage, excepting claims for injury or damage arising from activities of the department of natural resources or the state in the use of the dock which are being conducted exclusively for the benefit of the department of natural resources or the state.

These rules are intended to implement Iowa Code sections 461A.4, 461A.25, 462A.2 and 462A.27.

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CHAPTER 34
COMMUNITY FORESTRY GRANT PROGRAM (CFGP)

571—34.1(461A) Purpose. The purpose of this chapter is to define procedures for cost sharing between state and local public agencies or volunteer organizations to assist them in developing comprehensive community street and park tree programs or to establish community tree planting projects on public lands that benefit the citizens of the state of Iowa.

571—34.2(461A) Definitions.

"Administrator" means the administrator of the forestry division of the department, also known as the state forester.

"CFGP" means the community forestry grant program.

"Community" means an incorporated city, town or village within the state of Iowa.

"Department" means the Iowa department of natural resources.

"Director" means the director of the Iowa department of natural resources.

"Division" means the forestry division of the Iowa department of natural resources.

"Iowa urban and community forestry council" means the group of professionals and volunteer leaders selected by the forestry division administrator to advise the division on urban and community forestry programs, also known as the council.

"Organization" means governmental or nongovernmental agencies, formal groups such as service clubs and other volunteer groups.

"Public lands" means land owned by state, county or local governments.

"Urban and community forestry" means the planning, planting and maintenance of trees in communities or public recreation areas.

571—34.3(461A) Availability of funds. Funds to institute the CFGP program may be derived through federal allocations pursuant to Section 9 of the Cooperative Forestry Assistance Act (16 U.S.C. 2105), from state legislative allocations and other sources.

571—34.4(461A) Eligibility of forestry development projects. Forestry development grants (maximum $5,000) may include, but are not necessarily limited to, the following:

1. Hiring a new full- or part-time city forester.
2. Internships for forestry, horticulture or landscape architect to perform community forestry work.
3. Completing a 100 percent street and park tree inventory.
4. City tree ordinance development or revision.
5. City employee or volunteer community forestry training.
6. Development of community forestry master plans.
7. Community forestry youth and adult education programs.
8. City forestry planting site design development.

571—34.5(461A) Eligibility of community tree planting projects. A cost-share grant (maximum $5,000) is available for a community or organization for landscape and conservation tree planting projects.

571—34.6(461A) Projects not eligible. The following types of projects are not eligible for assistance from the CFGP:

1. Acquisition of land.
2. Replacement of normally allocated local government funds.
3. Any type of development or planting that will not improve public benefits or safety.
4. Projects with a total grant request of less than $500.
5. Any project or project costs incurred prior to notification of the sponsoring agency by the forestry division administrator that a grant has been approved.

571—34.7(461A) Eligible applicants. Eligible projects may be submitted by regional or local units of Iowa state, county or city government, local governmental departments, school districts, volunteer organizations and service clubs involved with local urban and community forestry resources. Eligible projects must occur within the state of Iowa.

571—34.8(461A) Establishing project priorities. The forestry division administrator shall appoint a minimum three-member ranking committee representing a cross section of the Iowa urban and community forestry council for the purpose of reviewing, establishing priorities for cost sharing and ranking applications for approval by the administrator. This committee will review and rank all proposals received on a competitive basis for demonstrated need, cash match, community involvement, new project, cost effectiveness, meeting Tree City USA requirements, storm damage documentation and other issues pertinent to urban forestry in Iowa.

571—34.9(461A) Application procedures. Announcements concerning the application procedures will be issued by the administrator each year. A maximum six-page proposal must be received by the Forestry Division Administrator, Wallace State Office Building, Des Moines, Iowa 50319-0034, no later than 4:30 p.m. on the last working day identified in the announcement. The proposal should briefly describe the eligible applicant and detail project request, total budget, source of match and completion date. For community tree planting projects, an 8″ × 11″ site map must be included in addition to the proposal.

This proposal must be signed by an authorized official of state, regional or local government under whose jurisdiction the project will occur, indicating that the project funds will be spent in accordance with the proposal and all applicable federal and state laws, rules and regulations. The applicant must sign a statement relinquishing the department or the Iowa urban and community forestry council from any liability associated with this project.

571—34.10(461A) Requirements for funding. In order to qualify for funding, state, regional or local units of government, school districts, volunteer organizations and service clubs must comply with the following requirements:

34.10(1) The project(s) must be on public land within the state of Iowa (for example, streets, boulevards, parks, schools, cemeteries).

34.10(2) A $1 for $1 minimum match of requested funds is required.

34.10(3) In-kind contributions are allowed for the forestry development projects only if specific for the proposed project. Tree planting projects require cash match $1 for $1 only. All in-kind costs for the forestry development projects must be documented. Allowable in-kind costs include, but are not limited to, the following:

a. Volunteer labor (reasonable local rates).
b. Value of locally purchased or donated trees to be planted on public areas.
c. Value of wood mulch and other tree protective devices (reasonable local rates).

34.10(4) Only plant materials, products and services purchased from Iowa firms are eligible for tree planting projects.

571—34.11(461A) Project agreements.

34.11(1) A cooperative agreement approved by the administrator between the department and the local grant recipient describing the work to be accomplished and specifying the amount of the grant and the project completion date will be negotiated as soon as possible after a grant has been approved. Maximum time period for project completion shall be stated in the grant announcement, unless an extension approved by the administrator is authorized.

34.11(2) Cooperative agreements between the department and the local grant recipient may be amended to increase or decrease project scope or to increase or decrease project costs and fund assistance. Any increase in fund assistance will be subject to the availability of funds. Amendments to increase scope or fund assistance must be approved by the administrator before work is commenced or additional costs are incurred.

571—34.12(461A) Reimbursement procedures. Financial assistance from the community forestry grant program will be in the form of reimbursement grants which will be made on the basis of the approved percentage of all eligible expenditures up to the amount of the approved grant.

Reimbursement requests must be submitted by the grant recipient on project billing forms provided by the department at the completion of the project.

For forestry development projects and community tree planting projects, grant recipients shall provide documentation as required by the department to substantiate all project expenditures.

Tree planting grant recipient organizations must be willing to sign a ten-year maintenance agreement for trees planted on public lands before reimbursement of costs is approved.

These rules are intended to implement Iowa Code section 461A.2.

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CHAPTER 35
Reserved

CHAPTER 14
FAIR INFORMATION PRACTICES
(Uniform Rules)

14.1(17A,22) Definitions
14.3(17A,22) Requests for access to records
14.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
14.7(17A,22) Consent to disclosure by the subject of a confidential record
14.8(17A,22) Notice to suppliers of information

CHAPTER 15
Reserved

CHAPTER 16
NURSE LICENSURE COMPACT

16.1(152) Definitions
16.2(152) Issuance of a license by a compact party state
16.3(152) Limitations on multistate licensure privilege
16.4(152) Information system

2.3(2) Requirements of the heads of the programs:

a. Currently licensed as a registered nurse in Iowa, including persons licensed in another state and recognized for licensure in Iowa pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8.

b. Two years of experience in clinical nursing.

c. Two years of experience in nursing education.

d. The applicable academic qualifications:

(1) Heads of programs who are employed on July 1, 1992, shall be considered adequately prepared as long as they remain in that position.

(2) Heads of programs who are hired after July 1, 1992, shall have a master's or doctoral degree with a major in nursing at either level at the time of hire. The date of hire is the first day employed with compensation at a particular nursing education program.

e. Preparation in education or administration.

f. In addition to the above:

(1) Programs offering the baccalaureate and higher degrees in nursing.

1. A doctoral degree with a nursing major at the baccalaureate, master's, or doctoral level.
2. Two years of experience in nursing education at the baccalaureate level or higher.

(2) Programs offering formal advanced practice education in nursing.

1. Education equal to this program offering.
2. Two years of clinical experience in the specialty area.

g. Submission of a detailed description of qualifications to the board office. A program head appointed after July 1, 1992, shall submit a detailed description of qualifications by which the individual's compliance with this subrule can be determined. This information shall be submitted within one month of appointment.

h. The nursing education programs in the community colleges shall have one designated head of the program per community college district.

i. The head of a program shall be responsible for the administration of the program.

655—2.4(152) Resources of the controlling institution.

2.4(1) The controlling institution is responsible for provision of resources adequate to meet program needs.

a. Human resources.

(1) Head of program.

(2) Faculty.

(3) Secretarial and other support and staff services to ensure appropriate use of faculty time and expertise.

b. Physical resources.

(1) Classrooms, conference rooms, laboratories, offices, and equipment.

(2) Student facilities.

c. Library resources. Adequate and accessible holdings and space.

2.4(2) The agencies and services utilized for learning experiences are adequate in number and kind to meet program objectives.

655—2.5(152) Curriculum.

2.5(1) The curriculum, a program of study developed by the faculty, shall:

a. Reflect the philosophy, organizing framework, purpose, and objectives of the program.

b. Identify the terminal behavioral outcomes.

c. Be in accordance with current educational, societal, and nursing standards.

d. Be consistent with the laws governing the practice of nursing.

e. Ensure sufficient preparation for the safe and effective practice of nursing.

f. Include teaching/learning experiences and learning strategies selected to meet curriculum objectives.

g. When offered within a college or university:

(1) Be comparable to the quality and requirements of other degree programs within that institution.

(2) Be planned within the college calendar.

(3) Assign credit hours for lecture and clinical or laboratory experience comparable with the college pattern.

2.5(2) Curricula for practical nursing programs shall include didactic content and practice in nursing with a focus on supportive and restorative health care for individuals through the life span.

a. Didactic content shall include life sciences, behavioral sciences, legal and ethical aspects as related to the role of the practical nurse, medical nursing, surgical nursing, maternity nursing, nursing of children, and gerontological nursing.

b. Learning experiences shall include care during acute, episodic, and chronic illnesses; observation; communication; technical skills; equipment use; and problem solving.

2.5(3) Curricula for basic nursing education programs shall include didactic content and practice in nursing which focuses on attaining, maintaining, and regaining health for individuals and groups throughout the life span.

a. Didactic content shall include content in nursing of clients with medical-surgical therapies, nursing of childbearing and childrearing families, mental health nursing, and nursing through the aging process. Baccalaureate programs shall include nursing research and nursing in the community.

b. Learning experiences shall include care during acute, episodic, and chronic illnesses with emphasis given to health promotion, illness prevention, and rehabilitative intervention.

c. Content in history and trends as related to nursing and professional, legal, and ethical aspects of nursing.

d. Content in the principles of leadership, management, and patient education.

e. Supporting content from the biological-physical, behavioral/social sciences.

2.5(4) Curricula for programs granting a baccalaureate degree to registered nurses shall include didactic content and practice in nursing which will enable the student to achieve competencies comparable to outcomes of baccalaureate education.

2.5(5) Curricula for programs granting a master's degree to registered nurses shall include didactic content and practice in nursing which will enable the student to achieve competencies comparable to outcomes of baccalaureate education and master's education.

2.5(6) Curricula of formal advanced practice education programs in nursing shall:

a. Provide advanced didactic content and practice in a specialty area of nursing.

b. Address the role of advanced registered nurse practitioners.

2.5(7) Curricula of master's and doctoral nursing degree programs shall:

a. Provide for the in-depth study of nursing science including theory, clinical, and research components.

b. Provide for the study in role areas such as nursing education, administration, or clinical practice.

655—2.6(152) Faculty.

2.6(1) Faculty requirements for programs are as follows:

a. There shall be a sufficient number of adequately prepared faculty to meet program objectives. Adequately prepared shall mean:

(1) A head of the program who is hired after July 1, 1992, shall have a master's or doctoral degree with a major in nursing at either level at the time of hire.

(2) A faculty member who is hired after July 1, 1992, shall meet the requirements set forth in subrule 2.6(2).

(3) Faculty members and heads of programs employed on July 1, 1992, shall be considered adequately prepared as long as they remain in that position.

b. Written personnel policies and position descriptions shall be provided.

c. A faculty development program shall be designed to further the competence of individual faculty members and the faculty as a whole.

d. There shall be a written teaching load policy.

e. There shall be a nursing faculty organization which shall operate according to written bylaws and meet on a regular basis. Minutes shall be recorded and available for reference.

f. In practical and basic nursing programs a ratio of one faculty to a maximum of ten students shall be required in those practice situations involving direct patient care.

2.6(2) Requirements of faculty members who teach nursing are as follows:

a. Current licensure as a registered nurse in Iowa. Individuals are currently licensed when licensed in another state and recognized for licensure in this state, pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8.

b. Two years of experience in clinical nursing.

c. The applicable academic qualifications:

(1) A faculty member who is hired to teach in a basic RN program after July 1, 1992, shall have at least a baccalaureate degree with a major in nursing or an applicable field at the time of hire. This person shall make annual progress toward the attainment of a master's or doctoral degree with a major in nursing or an applicable field. One degree shall be in nursing.

1. Applicable fields include but are not limited to education, counseling, psychology, sociology, health education, health administration, public health. One who wishes to fulfill this requirement with education in an applicable field not listed may petition the board for a determination of applicability.

2. The date of hire is the first day employed with compensation at a particular nursing education program.

3. Annual progress shall mean a minimum of one course per year taken as part of an organized plan of study.

(2) A faculty member who is hired to teach after July 1, 1992, in a practical nursing program or the first level of an associate degree nursing program with a ladder concept shall have a baccalaureate or higher degree in nursing or an applicable field at the time of hire. The date of hire is the first day employed with compensation at a particular nursing education program.

(3) The majority of faculty teaching in a master's program must hold earned doctorates with a major in nursing at the master's or doctoral level. A faculty member without an earned doctorate shall have a master's degree in nursing, advanced level certification in the clinical specialty area in which the individual teaches, by a national professional nursing organization approved by the board, and current registration as an advanced registered nurse practitioner in the state(s) in which the individual teaches.

(4) Those faculty hired only to teach in the clinical setting shall be exempted from subparagraphs (1) and (2) if the faculty member is closely supervised to ensure proper integration of didactic content into the clinical setting. If hired after July 1, 1992, those hired to teach only in the clinical setting shall have a baccalaureate degree in nursing or an applicable field, or shall make annual progress toward the attainment of such a degree. Annual progress shall mean a minimum of one course per year taken as part of an organized plan of study. The date of hire is the first day employed with compensation at a particular nursing education program.

(5) The head of a program may petition the board for a waiver from the requirements in subrules 2.3(2), 2.6(1), paragraph *"a,"* and 2.6(2). The board shall require the program to demonstrate its efforts and progress in meeting these requirements. The board, if it determines a waiver is warranted because of unusual or unforeseen circumstances, shall issue a waiver for a limited period of time and may indicate conditions which must be met.

d. Submission of a detailed description of qualifications to the board office.

(1) Each program head shall submit a list of all faculty teaching on July 1, 1992, along with a detailed description of qualifications by which each faculty member's compliance with this subrule can be determined. The list shall be submitted within one month of notification by the board of this requirement. The detailed description of each faculty member's qualifications shall be submitted within another month.

(2) The board shall monitor each program's progress in meeting this subrule at least annually in the annual reports.

2.6(3) Functions of faculty.

a. Develop, implement, and evaluate the purpose, philosophy, and objectives of the program.

b. Design, implement, evaluate, and revise the curriculum.

c. Provide students with the written policies as specified in subrule 2.7(1).

d. Participate in academic advising and guidance of students.

e. Provide for admission, promotion, and graduation of students.

f. Provide for student, self, and peer evaluation of teaching effectiveness.

g. Participate in activities to improve competency in area of responsibility.

655—2.7(152) Program responsibilities.

2.7(1) *Policies affecting students.* Programs shall include provisions for the development, implementation, and communication of the following student policies:

a. Admission/enrollment. Licensure if applicable according to 655—subrule 3.2(1).

b. Transfer or readmission.

c. Withdrawal.

d. Progression.

e. Grading system.

f. Suspension or dismissal.

g. Graduation.

h. Holiday and leave of absence.

i. Health.

j. Counseling.

k. Grievance procedure.

i. Curriculum plan.

j. Descriptions of resources, clinical facilities, preceptorship experiences, and contractual arrangements.

k. Copy of audited fiscal reports, including a statement of income and expenditures.

l. Goals for present academic year.

m. Program catalog.

2.11(2) *Special reports.* The program shall notify the board of the following:

a. Change of controlling institution. Information shall include official names of the programs and controlling institution, organizational chart of the controlling institution, and names of administrative officials.

b. Changes in administrative personnel in the program or the controlling institution.

c. Opening of a new site or campus.

2.11(3) *Changes requiring board approval.*

a. These changes require the submission of eight copies of the proposed change at least three weeks prior to the next regularly scheduled board meeting and include but need not be limited to the following:

(1) Changes in the curriculum which lengthen or shorten the program.

(2) Addition or deletion of clinical or didactic credit hours in a course.

(3) Changes in course requirements for graduation.

b. Changes requiring the submission of one copy of the proposed change. A board representative shall review the proposed change for approval. If the change is not approved, seven additional copies shall be requested and the matter shall be submitted for board approval. These changes include but need not be limited to the following:

(1) Changes in the philosophy, objectives, or organizing framework used to define the curriculum.

(2) Change in the predominant method of instruction (e.g., where a course taught by faculty is shifted to computer, programmed self-study, or correspondence).

(3) Rearrangement of the sequence of required courses.

These rules are intended to implement Iowa Code section 152.5 and 2000 Iowa Acts, House File 210.

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CHAPTER 3
LICENSURE TO PRACTICE
REGISTERED NURSE/LICENSED PRACTICAL NURSE

[Prior to 5/23/84, IAC, appeared as separate Chapters 3 and 4]
[Prior to 8/26/87, Nursing Board[590] Ch 3]

655—3.1(17A,147,152,272C) Definitions.

Accredited or approved nursing program. An accredited or approved nursing program means a nursing education program whose status has been recognized by the board or by a similar board in another state that prepares individuals for licensure as a licensed practical nurse, registered nurse, or registration as an advanced registered nurse practitioner; or grants a baccalaureate, master's, or doctorate degree with a major in nursing.

Applicant. Applicant means a person who is qualified to take the examination or apply for licensure.

Delinquent licensee. Delinquent licensee means a registered nurse/licensed practical nurse who has failed to renew the license or place it on inactive status as provided by subrule 3.7(5) by the fifteenth day of the month following the expiration date.

Endorsement. Endorsement means the process by which a registered nurse/licensed practical nurse licensed in another state becomes licensed in Iowa.

Examination. Examination means any of the tests used to determine minimum competency prior to the issuance of a registered nurse/licensed practical nurse license.

Fees. Fees means those fees collected which are based upon the cost of sustaining the board. The nonrefundable fees set by the board are as follows:

1. For the original license based on the registered nurse examination, $75.
2. For the original license based on the practical nurse examination, $75.
3. For a registered nurse/licensed practical nurse license by endorsement, $101.
4. For registration as an advanced registered nurse practitioner, $21 per year, or any portion thereof.
5. For a certified statement that a registered nurse/licensed practical nurse is licensed in this state or registered as an advanced registered nurse practitioner, $25.
6. For reactivation of a license to practice as a registered nurse/licensed practical nurse, based on $27 per year, or any portion thereof, totals $81 for a license lasting more than 24 months up to 36 months.
7. For the renewal of a license to practice as a registered nurse/licensed practical nurse, $81 for a three-year period.
8. For a duplicate or reissued license/original certificate to practice as a registered nurse/licensed practical nurse, or registration card/original certification to practice as an advanced registered nurse practitioner, $20.
9. For a registered nurse/licensed practical nurse late renewal, $50, plus the renewal fee as specified in paragraph "6" of this rule.
10. For a registered nurse/licensed practical nurse delinquent license fee, $100, plus all renewal fees to date due, the total back renewal fees shall not exceed $250.

11. For a check returned for any reason, $15. If licensure/registration had been issued by the board office based on a check for the payment of fees and the check is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification by certified mail of the returned check, the license/registration is no longer in effect. The licensee's status returns to what it would have been had this license/registration not been issued.

12. For a copy of the Law of Iowa as it Pertains to the Practice of Nursing, $2.

13. For a copy of the Iowa Administrative Code, Nursing Board[655], $2.

14. For a certified copy of an original document, $20.

15. Reserved.

16. For special licensure, $62.

17. For a subscription to Notices of Intended Action for the period July 1 to June 30, $25 or for the period January 1 to June 30, $12.50.

Inactive licensee. Inactive licensee means a registered nurse/licensed practical nurse who has requested to be placed on inactive status.

Lapsed license. A lapsed license means an expired license which is either late or delinquent.

Late licensee. Late licensee means a registered nurse/licensed practical nurse who has failed to renew the license or place it on inactive status as provided by subrule 3.7(5) by the expiration date on the license. The time between the expiration date and the fifteenth day of the month following the expiration date is considered a grace period or late period.

NCLEX. NCLEX means National Council Licensure Examination, the currently used examination.

Overpayment. Overpayment means any overpayment of fees less than $10 received by the board that shall not be refunded.

Reactivation. Reactivation means that process whereby an inactive licensee obtains a current license.

Reinstatement. Reinstatement means that process by which a delinquent licensee obtains a current license.

Temporary license. Temporary license means a license issued on a short-term basis for a specified time pursuant to subrule 3.5(3).

Verification. Verification means that process whereby the board will provide a certified statement that a registered nurse/licensed practical nurse is licensed, inactive, or lapsed, or an advanced registered nurse practitioner is registered in this state.

This rule is intended to implement Iowa Code section 147.80.

655—3.2(17A,147,152,272C) Mandatory licensure.

3.2(1) A person who practices nursing in the state of Iowa as defined in Iowa Code section 152.1, outside of one's family, shall have a current Iowa license, whether or not the employer is in Iowa and whether or not the person receives compensation. The nurse shall maintain a copy of the license and shall have it available for inspection when engaged in the practice of nursing in Iowa.

a. A person denied licensure or not having a current active Iowa license because of disciplinary action by the board, or having an encumbered license in another state, may not take a nursing course with a clinical component.

b. A nurse who has been licensed in another country and does not hold a current active license because of disciplinary action may not take a nursing course with a clinical component.

3.2(2) Current Iowa licensure is mandatory except when:

a. A nurse who resides in another state is recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8. The nurse shall maintain a copy of the license and shall have it available for inspection when engaged in the practice of nursing in Iowa.

b. A nurse who resides out of state, holds an active out-of-state license, and provides only intermittent consultation which shall not include patient care.

c. A nurse who holds an active license in another state provides services to patients in Iowa only during interstate transit.

d. A nurse who holds an active license in another state provides emergency services while serving on a Red Cross disaster team.

e. A nurse who holds an active license in any state or who has completed a nursing education course of study in another country provides nursing services incidental to a course of study while enrolled in an approved nursing education program.

This rule is intended to implement Iowa Code section 147.2.

655—3.3(17A,147,152,272C) Qualifications for licensure.

3.3(1) Applicants shall meet the requirements as set forth in Iowa Code sections 147.3 and 152.7.

a. Graduation from an accredited high school or its equivalent prior to the examination. High school equivalency shall be in conformity with the requirements of the department of education, state of Iowa.

b. Graduation from an approved nursing program as defined in Iowa Code section 152.5(1) or completion of a course of study as defined in Iowa Code section 152.7(3), prior to the examination. Theory and clinical experience shall be completed before the examination and shall include medical nursing, surgical nursing, obstetric nursing, and nursing of children. In addition, registered nurse applicants shall have had theory and clinical experience in psychiatric nursing prior to the examination.

c. Passing the examination by the standards determined by the board.

d. Approval by the board of those with a past felony record. The board determines the eligibility for licensure of a felony applicant on the felony's relationship to nursing.

3.3(2) Exceptions to the qualifications for licensure. Applicants for licensure in Iowa must meet the qualifications in effect in Iowa at the time of the applicant's graduation from nursing school. The relevant requirements listed in subrule 3.3(1) are subject to the following exceptions:

a. Graduation from high school or its equivalent was not required of registered nurse applicants until 1930 or of licensed practical nurse applicants until 1963.

b. If graduation from a nursing program was prior to 1952, a license will be granted according to board-approved guidelines.

c. Registered nurse graduates prior to 1951 are not required to have psychiatric nursing or be tested in psychiatric nursing.

d. A person licensed as a registered nurse in another state by waiver shall be accepted for Iowa licensure only if the waiver period corresponds to that in Iowa.

e. Exceptions related to examinations:

(1) Before 1946, the registered nurse applicant shall have passed a written test prepared by a licensing board of another state.

(2) A practical nurse applicant must have written the same examination as that administered in Iowa and achieved a score established as passing for that test by the board unless the applicant was graduated and licensed prior to July 1951.

(3) After June 1976, an applicant who took the State Board Test Pool Examination (SBTPE) shall have passed that examination within four writings in order to be eligible for an Iowa license. Prior to that date, there was no limit on the number of writings. An applicant who failed the SBTPE but wrote it less than four times is eligible to take the NCLEX an unlimited number of times.

(4) An applicant whose national examination scores do not meet the Iowa requirements in effect at the time of the examination and who wishes to become licensed in Iowa shall appeal to the board. The board may require the applicant to produce evidence of working experience or successful completion of a refresher course. The board may require the applicant to rewrite the current examination.

This rule is intended to implement Iowa Code sections 147.2 and 152.7(3).

655—3.4(17A,147,152,272C) Licensure by examination.

3.4(1) *Qualifications for licensure by examination.* Applicants shall meet qualifications for licensure as set forth in subrule 3.3(1).

3.4(2) *Examination.* The board contracts with the National Council of State Boards of Nursing, Inc., to utilize the examination.

a. The passing standard for the examination is determined by the board.

(1) NCLEX-PN results will be reported to the candidates as pass or fail.

(2) NCLEX-RN results will be reported to the candidates as pass or fail.

b. The examination shall be administered in Iowa.

c. The examination shall be administered in accordance with the manual prepared by the National Council of State Boards of Nursing, Inc., for the administration of the NCLEX.

d. The candidate shall present identification for admission to the testing center in accordance with the policies of the National Council of State Boards of Nursing, Inc.

e. Licensure examination statistics are available to the public.

3.4(3) *Application—Iowa graduates.* Application for licensure by examination to practice as a registered nurse in Iowa shall be made according to the following process.

a. The board is responsible for the following:

(1) At least twice a year, the board staff shall request the head of each nursing program in Iowa to submit information about the students who are anticipated to complete the program.

(2) Upon return of the information about the students who are anticipated to complete the program, an adequate supply of application forms and instructions for filing shall be sent to the head of the nursing program.

(3) The board shall confirm or deny the eligibility of each applicant upon receipt of the following materials:

Completed application form (submitted by the applicant).

Original license fee (submitted by the applicant).

Notification of completion of the NCLEX registration process (confirmed by NCLEX).

Official nursing transcript denoting the date of entry and date of graduation from an approved nursing education program.

b. An applicant who has graduated from an approved registered nurse program and has failed NCLEX-RN is eligible to take the NCLEX-RN an indefinite number of times.

c. An applicant who has graduated from an approved practical nurse program and has failed the State Board Test Pool Examination less than four times is eligible to take the NCLEX-PN an indefinite number of times.

d. An applicant who has graduated from an approved registered nurse program and has failed the State Board Test Pool Examination less than four times is eligible to take the NCLEX-RN an indefinite number of times.

e. An applicant who fails the examination shall be required to refile the following before taking another examination:

(1) The board application form.

(2) The original license fee.

(3) The NCLEX registration.

(4) The NCLEX registration fee.

3.4(9) *Certificate of licensure by examination.* Upon completion of the relevant qualifications for licensure by examination defined in these rules, the board shall issue a certificate of licensure by examination and a current license to practice as a registered nurse/licensed practical nurse.

a. A licensee shall use the relevant title registered nurse/licensed practical nurse and relevant initials R.N./L.P.N.

b. A licensee is required to hold a certificate and license. If a certificate or license is stolen or lost, the licensee shall apply for a duplicate as specified in subrule 3.7(7).

This rule is intended to implement Iowa Code sections 147.36, 147.80, 152.7(3), and 152.9.

655—3.5(17A,147,152,272C) Licensure by endorsement.

3.5(1) *Qualifications for licensure by endorsement.* The endorsee must meet the qualifications for licensure defined in subrule 3.3(1).

3.5(2) *Applicants currently licensed in another state.* Application for licensure to practice as a registered nurse or licensed practical nurse by endorsement shall be made according to the following process:

a. The board is responsible for the following:

(1) Upon request, application forms and instructions shall be sent to the applicant.

(2) Evaluation of credentials to determine that the applicant has met all qualifications for licensure.

(3) Issuance of an original certificate and current license to practice following determination of eligibility and upon receipt of the following materials:

Completed application form (submitted by the applicant).

Endorsement fee (submitted by the applicant).

Official nursing transcript denoting date of entry and date of graduation (submitted by the nursing program).

Verification of licensure form (submitted by state of original licensure).

b. The applicant is responsible for the following:

(1) Submission of a completed board application form.

(2) Submission of the endorsement fee, made payable to the Iowa Board of Nursing. The fee, as outlined in rule 3.1(17A,147,152,272C) is not refundable.

(3) Having the nursing program forward an official nursing transcript which denotes the date of entry and date of graduation.

(4) Submission of the verification of licensure form from the original state of licensure.

(5) Submission of evidence attesting that Iowa is the primary state of residence if the applicant is changing primary state of residence from another party state as outlined in rule 655—16.2(152).

(6) Submission of the above documents within 12 months from the date of receipt of the written request. The board reserves the right to destroy the documents after 12 months.

c. A license shall not be issued to an applicant whose license is under sanction by another state without approval of the board.

d. An applicant for endorsement who has had disciplinary action in another state shall submit all the materials required for endorsement and appear before the board. The board shall review the reasons for the out-of-state sanction and determine whether to grant licensure in Iowa. The board may determine special conditions for licensure.

e. A license shall not be issued to an applicant who fails to complete the application process within the allotted time. A license shall be issued when the application process is complete.

3.5(3) *Temporary license.* A temporary license shall be issued to an applicant who is licensed in another state if the applicant meets the qualifications for licensure as outlined in subrule 3.3(1) and has applied for licensure as a registered nurse/licensed practical nurse in Iowa. The board application form and endorsement fee as outlined in rule 3.1(17A,147,152,272C) and verification of licensure form shall be on file in the office of the board prior to the issuance of the temporary license.

a. A temporary licensee may use the appropriate title of registered nurse or licensed practical nurse and the appropriate abbreviation R.N. or L.P.N.

b. The temporary license must be signed by the licensee to be valid. The temporary license shall be issued for a period of 30 days. A second temporary license may be issued for a period not to exceed 30 days or at the discretion of the executive director.

c. A temporary license shall not be issued to an applicant whose license is under sanction by another state without approval of the board. The board may determine special conditions for licensure.

d. A temporary license shall not be issued to an applicant who fails to complete the application process within the allotted time. A license shall be issued when the application process is complete.

3.5(4) *Certificate of licensure by endorsement.* Upon completion of the endorsement procedures defined in these rules, the board shall issue a certificate of licensure by endorsement and a current license to practice as a registered nurse/licensed practical nurse. If a certificate or license is stolen or lost, the licensee shall apply for a duplicate as specified in subrule 3.7(7).

This rule is intended to implement Iowa Code sections 147.2 and 152.9.

655—3.6(17A,147,152,272C) Special licensure.

3.6(1) *Special licensure by endorsement.* A short-term special license may be granted by the board on an individual basis. The intent of the special license is to allow nurses licensed in a nonparty state to be licensed and to practice in Iowa for a fixed period of time and only under certain conditions. The purpose of the license is to allow those nurses not previously licensed in Iowa to provide care in a specialty area, to provide consultation or teaching where care is directed, or to obtain clinically based continuing education.

The application process for those currently licensed in a nonparty state who are eligible for endorsement is as follows:

a. Upon request the board shall send the application form and instructions to the applicant.

b. The application shall include identifying information, history of felony conviction, history of any disciplinary action or pending action against the individual's nursing license in another state, reason and circumstances surrounding the request for special endorsement.

c. The applicant shall submit the completed application form, special licensure fee as designated in rule 3.1(17A,147,152,272C), and evidence of current, active licensure in another state.

d. The board staff shall determine the validity of the request for special licensure by endorsement based on the duration, location, and need for the short-term nursing license and the absence of sanctions against the applicant's current license and absence of any felony convictions.

(1) If the application is incomplete, the board staff shall return it to the applicant.

(2) If the application shows a previous felony conviction or any disciplinary action or pending action against the individual's nursing license, the board staff shall return the application with an explanation that the applicant is not eligible for special licensure by endorsement. The applicant may be eligible for regular licensure by endorsement according to rule 3.5(17A,147,152,272C). The board staff shall send the regular endorsement application to the individual.

(3) If the application is complete and the request is valid, the board staff shall send the information to the board for its review.

(4) The board shall review the need for the special license by endorsement.

1. If the board determines the need exists for special licensure by endorsement, it shall grant a license. The license shall indicate its special nature and the duration and location for which it can be used. The period of licensure by special endorsement shall be determined by the board. Upon written request extensions may be granted by the board. A second special license by endorsement shall not be issued to the same person. A person with need for repeated special licensure may seek a waiver of this restriction.

2. If the board denies special licensure by endorsement, the individual may still be eligible for regular licensure by endorsement according to rule 3.5(17A,147,152,272C). The regular endorsement application shall be sent to the individual along with a reason for the denial of special licensure by endorsement.

e. This special licensure by endorsement shall be subject to all rules and regulations promulgated by the board except those pertaining to:

(1) Verification.
(2) Reactivation.
(3) Inactivation.
(4) Renewal.
(5) Late renewal.
(6) Continuing education requirements.

3.6(2) *Special licensure for those licensed in another country.* A special license may be granted by the board on an individual basis. The intent of the special license is to allow nurses licensed in another country who are not eligible for endorsement to practice in Iowa for a fixed period of time and only under certain conditions. The purpose of the license is to allow those nurses not previously licensed in Iowa to provide care in a specialty area, to provide consultation or teaching where care is directed to serve as a research assistant, to serve as a teaching assistant or to obtain clinically based continuing education.

a. Upon request the board shall send the application form and instructions to the applicant or sponsor.

b. The application shall include identifying information, history of felony conviction, history of licensure in any other state, and reason and circumstances surrounding the request for special licensure.

c. The applicant shall submit the completed application form, special licensure fee as designated in subrule 3.1(6), and a certificate by the Commission on Graduates of Foreign Nursing Schools (CGFNS), or evidence of a score of at least 500 on the Test of English as a Foreign Language (TOEFL).

d. The board staff shall determine the validity of the request for special licensure based on the duration, location, and need for the nursing license and absence of any felony convictions.

(1) If the application is incomplete, the board staff shall return it to the applicant.

(2) If the application shows a previous felony conviction, the board staff shall return the application with an explanation that the applicant is not eligible for special licensure. The applicant may be eligible for licensure by examination according to subrule 3.4(6). The board shall send the application for individuals educated in another country to the individual.

e. The board shall review the need for a special license.

(1) If the board determines the need exists for special licensure, it shall grant a license. The license shall indicate its special nature and the duration and location for which it can be used. The period of special licensure shall be determined by the board. Upon written request extensions may be granted by the board. A second special license will not be issued to the same person. A person with need for repeated special licensure may seek a waiver of this restriction.

(2) If the board denies a license, the individual may be eligible for licensure by examination according to subrule 3.4(6).

f. This special licensure shall be subject to all rules and regulations promulgated by the board except those pertaining to:

(1) Verification.
(2) Reactivation.

(2) An inactive licensee shall have completed 15 contact hours of continuing education as specified in 655—Chapter 5. The continuing education shall have been earned within the 12 months prior to reactivation.

(3) The reactivation fee is specified in rule 3.1(17A,147,152,272C).

(4) Upon receipt of the completed application, required continuing education materials, and fee, the board shall issue a current license to practice in Iowa. The license shall be issued for more than 24 months up to 36 months until the license can be placed in the three-year renewal cycle based on birth month. Expiration shall be on the fifteenth day of the birth month.

3.7(7) *Duplicate license or certificate.* The board shall issue a duplicate of a current license or original certificate upon written request of the licensee and payment of the fee specified in rule 3.1(17A,147,152,272C). If the current license is destroyed, lost, or stolen, a duplicate license is required as replacement.

3.7(8) *Reissue of a license.* If there is an error on the license or certificate made by the board office, no fee shall be charged for a reissued corrected license or certificate. A license may be reissued if a licensee desires to have a current name or address printed on the current license prior to renewal. Reissuance is optional; however, written notification to the board office of name or address change is mandatory as outlined in subrule 3.7(1). The board shall reissue a license per written request of the licensee and payment of the fee as specified in rule 3.1(17A,147,152,272C) or at the direction of the executive director.

655—3.8(17A,147,152,272C) Verification. Upon written request from the licensee or other state and payment of the verification fee as specified in rule 3.1(17A,147,152,272C), the board shall provide a certified statement to another state that a registered nurse/licensed practical nurse is licensed, inactive, or lapsed in Iowa.

These rules are intended to implement Iowa Code chapters 17A, 152, and 272C and Iowa Code sections 147.2, 147.10, 147.11, 147.36, 147.76, 147.80, 147.100, 152.1, 152.5, 152.9, and 152.10 and 2000 Iowa Acts, House File 2105.

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CHAPTER 6
NURSING PRACTICE FOR REGISTERED NURSES/LICENSED PRACTICAL NURSES

655—6.1(152) Definitions.

"Accountability" means being obligated to answer for one's acts, including the act of supervision.

"Advanced registered nurse practitioner (ARNP)" means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 4105, section 8, and is also registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

"Basic nursing education" means a nursing program preparing a person for initial licensure to practice nursing as a registered nurse or licensed practical nurse.

"Board" as used in this chapter means the Iowa board of nursing.

"Certified clinical nurse specialist" means an ARNP prepared at the master's level who possesses evidence of current certification as a clinical specialist in an area of nursing practice by a national professional nursing association as approved by the board.

"Certified nurse-midwife" means an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current certification by a national professional nursing association approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.

"Certified nurse practitioner" means an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing association approved by the board.

"Certified registered nurse anesthetist" means an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current certification by a national professional nursing association approved by the board.

"Competence in nursing" means having the knowledge and the ability to perform, skillfully and proficiently, the functions within the role of the licensed nurse.

"Minimum standards" means standards of practice that interpret the legal definition of nursing as well as provide criteria against which violations of the law can be determined.

"Nursing diagnosis" means a judgment made by a registered nurse, following a nursing assessment of individuals and groups about actual or potential responses to health problems, which forms the basis for determining effective nursing interventions.

"Nursing facility" means an institution as defined in Iowa Code chapter 135C. This definition does not include acute care settings.

"Nursing process" means ongoing assessment, nursing diagnosis, planning, intervention, and evaluation.

"Proximate area" means that the registered nurse analyzes the qualifications of the licensed practical nurse in relationship to nursing needs of the client in determining the appropriate distance within the building and the time necessary to be readily available to the licensed practical nurse.

"Unlicensed assistive personnel" is an individual who is trained to function in an assistive role to the registered nurse and licensed practical nurse in the provision of nursing care activities as delegated by the registered nurse or licensed practical nurse.

655—6.2(152) Minimum standards of nursing practice for registered nurses.

6.2(1) The registered nurse shall recognize and understand the legal implications within the scope of nursing practice. The scope of nursing practice considered to be minimum standards of nursing practice shall not be interpreted to include those practices currently ascribed to the advanced registered nurse practitioner.

6.2(2) The registered nurse shall utilize the nursing process in the practice of nursing, consistent with accepted and prevailing practice. The nursing process is ongoing and includes:

a. Nursing assessments about the health status of an individual or group.

b. Formulation of a nursing diagnosis based on analysis of the data from the nursing assessment.

c. Planning of nursing care which includes determining goals and priorities for actions which are based on the nursing diagnosis.

d. Nursing interventions implementing the plan of care.

e. Evaluation of the individual's or group's status in relation to established goals and the plan of care.

6.2(3) The registered nurse shall conduct nursing practice by respecting the rights of an individual or group.

6.2(4) The registered nurse shall conduct nursing practice by respecting the confidentiality of an individual or group, unless obligated to disclose under proper authorization or legal compulsion.

6.2(5) The registered nurse shall recognize and understand the legal implications of accountability. Accountability includes but need not be limited to the following:

a. Performing or supervising those activities and functions which require the knowledge and skill level currently ascribed to the registered nurse and seeking assistance when activities and functions are beyond the licensee's scope of preparation.

b. Assigning and supervising persons performing those activities and functions which do not require the knowledge and skill level currently ascribed to the registered nurse.

c. Using professional judgment in assigning and delegating activities and functions to unlicensed assistive personnel. Activities and functions which are beyond the scope of practice of the licensed practical nurse may not be delegated to unlicensed assistive personnel.

d. Supervising, among other things, includes any or all of the following:

(1) Direct observation of a function or activity.

(2) Assumption of overall responsibility for assessing, planning, implementing, and evaluating nursing care.

(3) Delegation of nursing tasks while retaining accountability.

(4) Determination that nursing care being provided is adequate and delivered appropriately.

e. Executing the regimen prescribed by a physician. In executing the medical regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules. If the medical regimen prescribed by the physician is not carried out, based on the registered nurse's professional judgment, accountability shall include but need not be limited to the following:

(1) Timely notification of the physician who prescribed the medical regimen that the order(s) was not executed and reason(s) for same.

(2) Documentation on the medical record that the physician was notified and reason(s) for not executing the order(s).

655—6.5(152) Additional acts which may be performed by licensed practical nurses.

6.5(1) A licensed practical nurse shall be permitted to supervise unlicensed assistive personnel under the provisions of Iowa Code section 152.1(4)*"b."*

a. Supervision, among other things, includes any or all of the following:

(1) Direct observation of a function or activity.

(2) Delegation of nursing tasks while retaining accountability.

(3) Determination that nursing care being provided is adequate and delivered appropriately.

b. Supervision shall be in accordance with the following:

(1) A licensed practical nurse working under the supervision of a registered nurse shall be permitted to supervise in an intermediate care facility for the mentally retarded or in a residential health care setting.

(2) A licensed practical nurse working under the supervision of a registered nurse shall be permitted to supervise in a nursing facility.

The licensed practical nurse shall be required to complete a curriculum which has been approved by the board and designed specifically for the supervision role of the licensed practical nurse in a nursing facility. The course must be presented by a board-approved nursing program or an approved provider of continuing education. Documentation of the completion of the curriculum as outlined in this subparagraph shall be maintained by the licensed practical nurse.

(3) A licensed practical nurse shall be entitled to supervise without the educational requirement outlined in subparagraph 6.5(1)*"b"*(2) if the licensed practical nurse was performing in a supervisory role on or before October 6, 1982. The licensed practical nurse being employed in a supervisory role after the enactment of these rules shall complete the curriculum outlined in subparagraph 6.5(1)*"b"*(2) within six months of employment.

(4) A licensed practical nurse working under the supervision of a registered nurse may direct the activities of other licensed practical nurses and unlicensed assistive personnel in an acute care setting in giving care to individuals assigned to the licensed practical nurse. The registered nurse must be in the proximate area.

6.5(2) A licensed practical nurse shall be permitted to practice as a diagnostic radiographer while under the supervision of a licensed practitioner provided that appropriate training standards for use of radiation-emitting equipment are met as outlined in 641—42.1(136C).

6.5(3) A licensed practical nurse who has completed a board-approved intravenous therapy certification course offered by a board-approved provider of continuing education shall be permitted to perform, in addition to the functions set forth in subrule 6.3(4), procedures related to the expanded scope of administration of intravenous therapy in a licensed hospital, licensed skilled nursing facility and a certified end-stage renal dialysis unit. The board-approved course shall incorporate the responsibilities of the nurse when providing intravenous therapy to children, adults and elderly adults. When providing intravenous therapy, the licensed practical nurse shall be under the supervision of the registered nurse. Procedures which may be assumed if delegated by the registered nurse are as follows:

a. Initiation of a peripheral intravenous line for continuous or intermittent therapy using an intermittent infusion device or a therapy cannula not to exceed three inches in length.

b. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of premixed electrolyte solutions or premixed vitamin solutions. The solutions must be prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

c. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of solutions containing potassium chloride that do not exceed 40 meq per liter and at a rate that does not exceed 10 meq per hour. The solutions must be prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

d. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of intravenous antibiotic solutions prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

e. Maintenance of the patency of peripheral intravenous lines with heparin irrigation solution or normal saline irrigation solution.

6.5(4) Acts which may not be delegated by the registered nurse to the licensed practical nurse are as follows:

a. Administration of medication by bolus or IV push except maintenance doses of analgesics via a patient-controlled analgesia pump set at a lock-out interval.

b. Administration of blood and blood products; vasodilators, vasopressors, oxytoxics, chemotherapy, colloid therapy, total parenteral nutrition, anticoagulants, antiarrhythmics, thrombolytics and solutions with a total osmolarity of 600 or greater.

c. Provision of intravenous therapy to a client under the age of 12 or any client weighing less than 80 pounds, with the exception of those activities authorized in the limited scope of practice found in subrule 6.3(4).

d. Provision of intravenous therapy in any setting except licensed hospitals, licensed skilled nursing facilities and certified end-stage renal dialysis units with the exception of those activities authorized in the limited scope of practice found in subrule 6.3(4).

6.5(5) To be eligible for intravenous therapy certification, the licensee shall hold a current unrestricted Iowa license and documentation of 2080 hours of practice as a licensed practical nurse and shall hold a current unrestricted Iowa license or an unrestricted license in another state recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 4105, section 8.

This rule is intended to implement Iowa Code chapters 136C and 152, and 2000 Iowa Acts, House File 2105.

655—6.6(152) Specific nursing practice for licensed practical nurses.

6.6(1) The licensed practical nurse shall be permitted to provide supportive and restorative care in the home setting under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician. When the licensed practical nurse provides care under the supervision of the registered nurse, the initial assessment and ongoing application of the nursing process shall be provided by the registered nurse.

6.6(2) The licensed practical nurse shall be permitted to provide supportive and restorative care to a specific student in the school setting in accordance with the student's health plan when under the supervision of and as delegated by the registered nurse employed by the school district.

6.6(3) The licensed practical nurse shall be permitted to provide supportive and restorative care in a Head Start program under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician if the licensed practical nurse were in this position prior to July 1, 1985.

6.6(4) The licensed practical nurse shall be permitted to provide supportive and restorative care in a camp setting under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician. When the licensed practical nurse provides care under the supervision of the registered nurse, the initial assessment and ongoing application of the nursing process are performed by the registered nurse. The licensed practical nurse is responsible for requesting registered nurse consultation as needed.

This rule is intended to implement Iowa Code sections 17A.3 and 152.1.

655—6.7(152) Specific nursing practice for registered nurses. A registered nurse, while circulating in the operating room, shall provide supervision only to persons in the same operating room.

This rule is intended to implement Iowa Code section 152.1.

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CHAPTER 7
ADVANCED REGISTERED NURSE PRACTITIONERS
[Prior to 8/26/87, Nursing Board[590] Ch 7]

655—7.1(152) Definitions.

"Advanced registered nurse practitioner (ARNP)" means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8, and is also registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

"Basic nursing education" as used in this chapter is a nursing program that prepares a person for initial licensure to practice nursing as a registered nurse.

"Board" as used in this chapter means Iowa board of nursing.

"Certified clinical nurse specialist" is an ARNP prepared at the master's level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice by a national professional nursing certifying body as approved by the board.

"Certified nurse-midwife" is an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current advanced level certification by a national professional nursing certifying body approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.

"Certified nurse practitioner" is an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing certifying body approved by the board.

"Certified registered nurse anesthetist" is an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current advanced level certification or recertification, as applicable, by a national professional nursing certifying body approved by the board.

"Collaboration" is the process whereby an ARNP and physician jointly manage the care of a client.

"Collaborative practice agreement" means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner.

"Consultation" is the process whereby an ARNP seeks the advice or opinion of a physician, pharmacist, or another member of the health care team. ARNPs practicing in a noninstitutional setting as sole practitioners, or in small clinical practice groups, shall regularly consult with a licensed physician or pharmacist regarding the distribution, storage, and appropriate use of controlled substances.

"Controlled substance" is a drug, substance, or immediate precursor in Schedules I through V of division II, Iowa Code chapter 124.

"National professional nursing certifying body" is a professional nursing certifying body approved by the board. Agencies approved by the board include the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the American College of Nurse-Midwives Certification Council, the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, the National Certification Board of Pediatric Nurse Practitioners and Nurses, the National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties, the Oncology Nursing Certification Organization, and the American Association of Critical Care Nurses Certification Corporation.

"Physician" means a medical doctor licensed under Iowa Code chapter 148 or osteopathic physician and surgeon licensed under Iowa Code chapter 150A.

"Prescriptive authority" is the authority granted to an ARNP registered in Iowa in a recognized nursing specialty to prescribe, deliver, distribute, or dispense prescription drugs, devices, and medical gases when the nurse is engaged in the practice of that nursing specialty. Registration as a practitioner with the Federal Drug Enforcement Administration and the Iowa board of pharmacy examiners extends this authority to controlled substances. ARNPs shall obtain a copy of the Iowa Pharmacy Law and Informational Manual. ARNPs are encouraged to subscribe to the Iowa Board of Pharmacy Newsletter.

"Referral" is the process whereby the ARNP directs the client to a physician or another health care professional for management of a particular problem or aspect of the client's care.

655—7.2(152) General requirements for the advanced registered nurse practitioner.

7.2(1) *Specialty areas of nursing practice for the advanced registered nurse practitioner.* The board derives its authority to define the educational and clinical experience that is necessary to practice at an advanced registered nurse practitioner level under the provisions of Iowa Code section 152.1(6)*"d."* The specialty areas of nursing practice for the advanced registered nurse practitioner which shall be considered as legally authorized by the board are as follows:

a. Certified clinical nurse specialist.

b. Certified nurse-midwife.

c. Certified nurse practitioner.

d. Certified registered nurse anesthetist.

7.2(2) *Titles and abbreviations.* A registered nurse who has completed all requirements to practice as an advanced registered nurse practitioner and who is registered with the board to practice shall use the title advanced registered nurse practitioner (ARNP). Utilization of the title which denotes the specialty area is at the discretion of the advanced registered nurse practitioner.

a. No person shall practice or advertise as or use the title of advanced registered nurse practitioner for any of the defined specialty areas unless the name, title and specialty area appear on the official record of the board and on the current license.

b. No person shall use the abbreviation ARNP for any of the defined specialty areas or any other words, letters, signs or figures to indicate that the person is an advanced registered nurse practitioner unless the name, title and specialty area appears on the official record of the board and on the current license.

c. Any person found to be practicing under the title of advanced registered nurse practitioner or using the abbreviation ARNP without being registered as defined in this subrule shall be subject to disciplinary action.

7.2(3) *General education and clinical requirements.*

a. The general educational and clinical requirements necessary for recognition by the board as a specialty area of nursing practice are as follows:

(1) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills as approved by the board; or

(2) Satisfactory completion of a formal advanced practice educational program of study in a nursing specialty area approved by the board and appropriate clinical experience as approved by the board.

b. Additional requirements. Nothing in this rule shall be construed to mean that additional general educational or clinical requirements cannot be defined in a specialty area.

7.2(4) *Application process.* A registered nurse who wishes to practice as an advanced registered nurse practitioner shall submit the following to the office of the board:

a. An advanced registered nurse practitioner application form which may be obtained from the office of the board.

b. A registration fee as established by the board.

c. A copy of the time-dated, advanced level certification by appropriate national certifying body evidencing that the applicant holds current certification in good standing; copy of official transcript directly from the formal advanced practice educational program maintaining the records necessary to document that all requirements have been met in one of the specialty areas of nursing practice as listed in subrule 7.2(1). The transcript shall verify the date of completion of the program/graduation and the degree conferred. A registered nurse may make application to practice in more than one specialty area of nursing practice.

7.2(5) *Initial registration.* The executive director or a designee shall have the authority to determine if all requirements have been met for registration as an advanced registered nurse practitioner. If it has been determined that all requirements have been met:

a. Official licensure records of the registered nurse shall denote registration as an advanced registered nurse practitioner as well as the specialty area(s) of nursing practice.

b. The registered nurse shall be issued a registration card and a certificate to practice as an ARNP which clearly denotes the name, title, specialty area(s) of nursing practice, and expiration date of registration. The expiration date shall be based on the same period of licensure to practice as a registered nurse.

7.2(6) *Registration completion.* The registered nurse shall complete the registration process within 12 months of receipt of the application materials. The board reserves the right to destroy the documents after 12 months.

7.2(7) *Denial of registration.* If it has been determined that all requirements have not been met, the registered nurse shall be notified in writing of the reason(s) for the decision. The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial by the executive director or designee.

7.2(8) *Application process for renewal of registration.* Renewal of registration for the advanced registered nurse practitioner shall be for the same period of licensure to practice as a registered nurse. The executive director or a designee shall have the authority to determine if all requirements have been met for renewal as an advanced registered nurse practitioner. A registered nurse who wishes to continue practice as an advanced registered nurse practitioner shall submit the following at least 30 days prior to the license expiration to the office of the Iowa board of nursing:

a. Completed renewal application form.

b. Renewal fee as outlined in rule 655—3.1(17A,147,152,272C), definition of "fees."

c. Copy of current time-dated, advanced level certification by appropriate national certifying body.

7.2(9) *Continuing education requirements.* Continuing education shall be met as required for certification by the relevant national certifying body, as outlined in 655—subrule 5.2(3), paragraph *"e."*

7.2(10) *Denial of renewal registration.* If it has been determined that all requirements have not been met, the applicant shall be notified in writing of the reason(s) for the decision. Failure to obtain the renewal will result in termination of registration and of the right to practice in the advanced registered nurse practitioner specialty area(s). The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial of the executive director or designee.

7.2(11) *Registration to practice as an advanced registered nurse practitioner restricted, revoked, or suspended.* Rescinded IAB 12/29/99, effective 2/2/00.

These rules are intended to implement Iowa Code sections 17A.3, 147.10, 147.53, 147.76, 147.107(6) and 152.1 and 2000 Iowa Acts, House File 2105.

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[Filed emergency 2/10/93 after Notice 1/6/93—published 3/3/93, effective 2/10/93]
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[Filed 12/10/99, Notice 10/6/99—published 12/29/99, effective 2/2/00]
[Filed emergency 6/9/00—published 6/28/00, effective 6/30/00]

CHAPTER 14
FAIR INFORMATION PRACTICES

The board of nursing hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to fair information practices printed in the first volume of the Iowa Administrative Code.

655—14.1(17A,22) Definitions.

"Agency." In lieu of the words "(official or body issuing these rules)", insert "board of nursing".

655—14.3(17A,22) Requests for access to records.

14.3(1) In lieu of the words "(insert agency head)", insert "Executive Director".

In lieu of the words "(insert agency name and address)", insert "the Board of Nursing, 1223 East Court Avenue, Des Moines, Iowa 50319".

14.3(2) *Office hours.* In lieu of the words "(insert customary office hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "Monday through Friday from 8 a.m. to 4:30 p.m., excluding legal holidays".

14.3(7) *Fees.*

c. In lieu of the words "(specify time period)", insert "one hour".

Delete the words "(An agency wishing to deal with search fees authorized by law should do so here.)".

655—14.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. In lieu of the words "(designate office)", insert "the board of nursing".

655—14.7(17A,22) Consent to disclosure by the subject of a confidential record. Delete the words "(and, where applicable, the time period during which the record may be disclosed)" and "(Additional requirements may be necessary for special classes of records.)".

655—14.8(17A,22) Notice to suppliers of information. Delete the words "(Each agency should revise its forms to provide this information.)".

[Filed 4/29/99, Notice 3/24/99—published 5/19/99, effective 7/1/99]

CHAPTER 15
Reserved

CHAPTER 16
NURSE LICENSURE COMPACT

655—16.1(152E) Definitions.

"Board" means a party state's regulatory body responsible for issuing nurse licenses.

"Information system" means the coordinated licensure information system.

"Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.

"Public" means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc.

655—16.2(152E) Issuance of a license by a compact party state.

16.2(1) A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include, but is not limited to:

a. A driver's license with a home address;

b. Voter registration card displaying a home address; or

c. Federal income tax return declaring the primary state of residence.

16.2(2) A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 30 days.

16.2(3) The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the 30-day period set out in 16.2(2) of this rule shall be stayed until resolution of the pending investigation.

16.2(4) The former home state license shall no longer be valid upon the issuance of a new home state license.

16.2(5) If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten business days, and the former home state may take action in accordance with that state's laws and rules.

655—16.3(152E) Limitations on multistate licensure privilege. All home state board disciplinary orders, agreed or otherwise, which limit the scope of the licensee's practice or require monitoring of the licensee as a condition of the order shall include the requirement that the licensee will limit the licensee's practice to the home state during the pendency of the order. This requirement may allow the licensee to practice in other party states with prior written authorization from both the home state and party state boards.

655—16.4(152E) Information system.

16.4(1) Levels of access.

a. The public shall have access to nurse licensure information limited to:

(1) The nurse's name.

(2) Jurisdiction(s) of licensure.

(3) License expiration date(s).

(4) Licensure classification(s) and status(es).

(5) Public emergency and final disciplinary actions, as defined by contributing state authority.

(6) The status of multistate licensure privileges.

b. Nonparty state boards shall have access to all information system data except current significant investigative information and other information as limited by contributing party state authority.

c. Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state authority.

16.4(2) The licensee may request in writing to the home state board review of the data relating to the licensee in the information system. In the event a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and within ten business days correct inaccurate data in the information system.

16.4(3) The board shall report to the information system within ten business days, a disciplinary action, agreement or order which requires participation in alternative programs or which limits practice or requires monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority), dismissal of complaint, and changes in status of disciplinary action, or licensure encumbrance.

16.4(4) Current significant investigative information shall be deleted from the information system within ten business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.

16.4(5) Changes to licensure information in the information system shall be completed within ten business days upon notification by the board.

These rules are intended to implement 2000 Iowa Acts, House File 2105.

[Filed emergency 6/9/00—published 6/28/00, effective 6/30/00]

21.800(422B) Local sales and services tax elections
21.801(422B) Form of ballot for local option tax elections
21.802(422B) Local vehicle tax elections
21.803(77GA,HF2282) Local sales and services tax elections for school infrastructure projects
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21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding
21.811 to 21.819 Reserved
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721—22.261(52) ES&S Model 100—system messages and solution codes. The numbers in the right-hand column of this chart correspond to solution codes printed after the chart. Precinct election officials and others working with this system shall be provided with the appropriate information from the chart.

System Message	When to expect this message	What to do
Accept blank ballot	Polls open: reading ballots	1
Audit log full	Polls open: reading ballots	4
Counter block failed CRC	Preelection testing and setup	6
Counters are full	Polls open: reading ballots	4
Counters are in overflow	Polls open: reading ballots	4
Counters cannot hold next count	Polls open: reading ballots	4
Counters cleared	Election day start-up	0
DRAM counter space bad	Polls open: reading ballots	4
Election definition failed CRC	Preelection testing and setup	4
Erroneous arithmetic operation	Anytime	4
Error accessing NVRAM	Polls open: reading ballots	4
Error getting machine ID	Election day start-up	4
Error in initializing modem	Modem transmission of results	5
Error in opening modem	Modem transmission of results	5
Error in receiving command request	Modem transmission of results	5
Error in receiving login request	Modem transmission of results	5
Error in receiving password request	Modem transmission of results	5
Error reading PCMCIA card	Polls open: reading ballots	4
Error reading system audit log	Polls open: reading ballots	4
Error seeking on PCMCIA card	Preelection testing and setup	6
Error setting line parameters	Preelection testing and setup	6
Error setting real time clock	Preelection testing and setup	6
Error writing PCMCIA card	Polls open: reading ballots	4
Error writing system audit log	Polls open: reading ballots	4
Event log failed CRC	Preelection testing and setup	6
Host rejects password	Modem transmission of results	5
Incompatible PCMCIA card format	Preelection testing and setup	6
Incompatible system log format	Preelection testing and setup	6
Invalid instruction	Polls open: reading ballots	4
Invalid memory reference	Polls open: reading ballots	4
Invalid Seq-Type-Split	Polls open: reading ballots	3
Memory parity error	Polls open: reading ballots	4

System Message	When to expect this message	What to do
Missing scanner block	Polls open: reading ballots	4
No ballots scanned	Preelection testing and setup	6
Overvote on race XXXXX	Polls open: reading ballots	2
Party preference race missing	Preelection testing and setup	6
PCMCIA card not inserted	Polls open: reading ballots	4
PCMCIA driver missing	Polls open: reading ballots	4
PCMCIA header section failed CRC	Polls open: reading ballots	6
Printer time-out	Polls open: reading ballots	4
Race results cross-check fail	Polls open: reading ballots	4
Results sent successfully	Modem transmission of results	0
Status results cross-check fail	Polls open: reading ballots	4
Successfully scanned ballot	Polls open: reading ballots	0
System audit log failed CRC	Polls open: reading ballots	4
Unable to initialize diverter	Election day start-up	4
Unable to initialize scanning system	Election day start-up	4
Unable to load signal handlers	Election day start-up	4
Unable to update counters	Polls open: reading ballots	4
Unload election definition		4
UNKNOWN ERROR, CODE: XXX	Polls open: reading ballots	4
Voltage too low	Anytime	check plug, then 4
100-Missed orientation marks	Polls open: reading ballots	3
101-Missed timing marks	Polls open: reading ballots	3
102-Missed orientation marks	Polls open: reading ballots	3
103-No data found	Polls open: reading ballots	3 or 4
104-Missed back side data mark	Polls open: reading ballots	4
105-Scanner interrupted	Polls open: reading ballots	3
106-Skipped orientation mark	Polls open: reading ballots	4
107-No timing marks found	Polls open: reading ballots	3
108-Inaccurate read	Polls open: reading ballots	3
109-Inaccurate read	Election day start-up	4
110-Inaccurate read	Polls open: reading ballots	3
111-Missed orientation marks	Polls open: reading ballots	3
112-Missed timing marks	Polls open: reading ballots	3
113-Invalid code mark	Polls open: reading ballots	3

System Message	When to expect this message	What to do
114-Invalid code type	Polls open: reading ballots	3
115-Invalid code mark	Polls open: reading ballots	3
116-Inaccurate read	Preelection testing and setup	6
117-Scanner interrupted	Preelection testing and setup	6
118-Scanner interrupted	Preelection testing and setup	6
119-Scanner interrupted	Preelection testing and setup	6
120-Scanner interrupted	Preelection testing and setup	6
121-Missed back orientation mark	Polls open: reading ballots	3
123-Scanner interrupted	Polls open: reading ballots	3 then 4
124-Scanner interrupted	Polls open: reading ballots	4
125-Error reading CMOS memory ballot	Preelection testing and setup	0
126-Error reading ballot	Polls open: reading ballots	3
127-Multiple ballots detected	Polls open: reading ballots	3
128-Diverter not initialized	Polls open: reading ballots	4
129-Diverter detection error	Polls open: reading ballots	4
130-Diverter error	Polls open: reading ballots	4
131-Ballot skewed	Polls open: reading ballots	3
132-Ballot dragged	Polls open: reading ballots	3 then 4
Unknown error code: XXX	Polls open: reading ballots	3 then 4
???-Unknown error on decode	Polls open: reading ballots	3 and 4
Unidentified mark - check your ballot	Polls open: reading ballots	7

Solution Codes

0. This is okay—you don't need to do anything.
1. Ballot decision—BLANK BALLOT: See Solution Code 2.
2. Ballot decision—OVERVOTED BALLOT:

If the voter is still there, offer the voter the opportunity to mark the ballot using the proper pen or pencil. If the voter declines the offer, press "accept" and reinsert the ballot. If the voter wants to correct the ballot press "reject." Mark the unreadable ballot or overvoted ballot "SPOILED" and keep it with other spoiled ballots. If the voter asks to use the original ballot as a guide to marking the new ballot, be sure the voter returns the unreadable ballot to you before placing the new ballot in the counter. If the voter has left the polling place, press "accept" and reinsert the ballot.

3. Ballot decision—Ballot not read by counter.

First ask the voter to reinsert the ballot. If the message repeats, take the voter aside to allow other voters to insert their ballots into the counter. With the permission of the voter, a precinct official shall inspect the ballot by comparing it with another of the same ballot type. Assure the voter that you will not reveal to anyone how the ballot was marked. There are several possible reasons for this message to appear.

• The ballot is flawed or misprinted. Solution: Replace ballot. Mark the unreadable ballot "SPOILED." Keep it with other spoiled ballots. If the voter asks to use the original ballot as a guide to marking the new ballot, be sure the voter returns the unreadable ballot to you before placing the new ballot in the counter.

• The wrong ballots were provided to the precinct officials. Check other ballot packages to see if all ballots are wrong. If all of the offices and candidates are the same and only coding or rotation is different, allow voters to use the ballots on hand. Notify the auditor's office for replacement ballots. Follow the procedures for Solution Code 4 until the correct ballots are delivered.

• The voter has attempted to use a ballot other than the one provided by the precinct officials. This voter shall be challenged for using an illegal ballot. Place the ballot in the special ballot envelope.

• The wrong memory card is loaded in the machine. See Solution Code 4.

4. Equipment problem.

Call the auditor's office, report the message and ask for a new memory card or counter. Until a replacement arrives, place all ballots in a sealed ballot box. When the new memory card or counter has been installed, two precinct officials of different parties shall feed all ballots into the counter, including all previously counted ballots and ballots received while the counter was not working.

5. Modem transmission problem.

Try again to send election results. If the error message repeats, be prepared to read the election results over the telephone. Call the auditor's office to report the problem.

6. Precinct election officials do not need instructions for this message.

7. Faint mark in voting target.

If the voter is present, ask the voter to re-mark or darken the marks on the ballot. If the voter finds faint marks that the voter did not intend as votes, the voter should be given a new ballot. Replace ballot. Mark the unreadable ballot "SPOILED." Keep it with other spoiled ballots. If the voter asks to use the original ballot as a guide to marking the new ballot, be sure the voter returns the unreadable ballot to you before placing the new ballot in the counter. If the voter has left the polling place, try to reinsert the ballot. If the message repeats, open the emergency ballot box and store the ballot until after the polls are closed, but before the results are printed. Any ballots in the emergency ballot box shall be fed into the ballot reader by two precinct officials of different parties. All ballots rejected with the error code "faint mark in voting target" shall be duplicated by two precinct officials of different parties and substituted for the defective ballot. Using a red pen, duplicate ballots shall be clearly labeled as such, and shall bear a serial number which shall also be recorded on the defective ballot. The original, defective ballot shall be enclosed in the envelope designated for the return of disputed ballots.

721—22.262 to **22.341** Reserved.

MARKING YOUR BALLOT

1. **Vote in secrecy.** Mark your ballot so no one else will know how you voted, unless you need help to vote.
2. **Study the specimen ballot carefully before voting on the "Official Ballot" card.** Your votes cannot be changed without spoiling the ballot.
3. **Use only the enclosed wire punch.** Do not use a pen or pencil.
4. **Unfold the security cover** and place the voting area of the ballot card over the foam backing.
5. **Voting for candidates.** After you have decided for whom you want to vote, find the position number printed next to the candidate's name.

position # → 1 CANDIDATE NAME

Then on the ***"Official Ballot" card*** punch out the black dot above that number. For some offices you may vote for more than one person. Watch for instructions under each office title that say, "Vote for no more than ___."

6. **Write-in votes.** If you want to vote for a person whose name is not listed on the specimen ballot:

a. Write the office, position number and the name of the person in the space provided inside the security cover, AND

b. Punch out the appropriately numbered black dot on the ***"Official Ballot" card***. Punching a dot without writing a name will not spoil the rest of the ballot.

7. **Overvoting.** If you punch more dots for an office than the number of people that can be elected, your vote for that office will not be counted.
8. **No extra marks.** Make no marks on the ballot card except the punches you make to vote.

RETURNING YOUR BALLOT

This ballot must be returned to the county auditor even if you don't vote.

1. **Affidavit.** After marking your ballot card,
   a. Read the affidavit on the affidavit envelope,
   b. Fill in all of the information requested, and
   c. Sign your name.
   d. Be sure to include today's date.

☞ **Your ballot will not be counted if you don't complete and sign the affidavit.**

2. **Use the secrecy envelope.** Fold the security cover over the ballot card; place it in the secrecy envelope.
3. **Do not return:**
   a. Specimen ballot listing offices and candidates.
   b. Wire punch.
   c. Styrofoam backing.
4. Put the secrecy envelope containing the ballot card in the affidavit envelope.
5. **Securely seal the affidavit envelope.** Your ballot will not be counted if the affidavit envelope is not sealed, or if the envelope has been opened and resealed.
6. Enclose the affidavit envelope in the envelope addressed to the county auditor.
7. **Postmark before election day.** If you mail your ballot, the envelope must be postmarked no later than the day before the election.
8. Return postage for this ballot is ___.
9. **Personal delivery.** You may also return your ballot in person, or send it back to the auditor with someone you trust. If the ballot is not mailed, it must be received by the auditor no later than ___ p.m. on election day. Do not return the ballot to a polling place; it will not be counted if you do.

IF YOUR BALLOT IS REJECTED BEFORE THE BALLOT ENVELOPE IS OPENED, YOU WILL BE NOTIFIED OF THE REASON.

22.462(8) In addition to the instructions provided above, the following information shall be inserted in the instructions provided to voters at the general election:

a. Voting on questions. To vote in favor of a question, punch out the black dot above the same number that appears next to the word "YES" in the question listed on the specimen ballot. To vote against a question, punch out the black dot with the same number as the word "NO."

b. Voting on judges. To vote to keep a judge in office, punch out the black dot on the ballot card with the same number as the one next to the word "YES" opposite the judge's name listed on the specimen ballot. To vote to remove a judge from office, punch out the black dot with the same number as the word "NO."

c. Straight party voting. To vote for all of the candidates of a political party, punch out the black dot on the ballot card with the same number as the one next to the name of that political party. You can override a straight party vote by voting for a candidate of another party. If you can vote for more than one person for an office, you must punch all of your choices if you are splitting your vote between candidates of two or more parties.

This rule is intended to implement Iowa Code sections 52.5 and 52.35.

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DIVISION IV
CORPORATIONS

CHAPTER 40
CORPORATIONS

[Prior to 7/13/88, see Secretary of State[750] Ch 2]

721—40.1(490,499,504A) Filing of documents. Documents pertaining to profit corporations, nonprofit corporations, and cooperative associations shall be delivered for filing to the office of Secretary of State, Hoover State Office Building, Des Moines, Iowa 50319.

40.1(1) A copy of a signature, however made, is acceptable with regard to documents delivered to the secretary of state for filing pursuant to Iowa Code chapter 490.

40.1(2) A document delivered to the secretary of state for filing pursuant to the Iowa business corporation Act, Iowa Code chapter 490, may be delivered by telecopier to (515)242-5953.

40.1(3) A document delivered by telecopier may be delivered at any time of day. The date and time of receipt printed on the document by the telecopier constitutes the date and time endorsement required by Iowa Code section 490.125(2).

40.1(4) A document delivered by telecopier shall be printed on paper measuring 8½" by 11", unless a copy of a larger document, reduced to 8½" by 11" paper, is acceptable to the filing party. The document received by the secretary of state via telecopier shall constitute the copy that is filed and returned to the corporation pursuant to Iowa Code section 490.125(2).

40.1(5) A document delivered by telecopier shall be accompanied by a cover sheet that provides the name, address, and telephone number of the filing party, and instructions as to the manner by which the filing fee will be paid. The filing fee may be billed to an account maintained by the filing party pursuant to rule 721—2.3(17A). The filing fee may be paid by any other means authorized by the secretary of state.

40.1(6) If a telecopier is used to deliver a document that is subject to the multiple copy requirement of Iowa Code section 490.130, the additional copy or copies shall be delivered by telecopier contemporaneously with the copy of the document to be filed.

40.1(7) A document delivered by telecopier for filing may be rejected if the print quality of the document is deemed by agency personnel to be unacceptable for microfilming purposes. The secretary of state will notify the filing party by telephone or regular mail of the rejection of a document pursuant to this subrule. The secretary of state will accept for filing the original copy of the document, effective on the date of the transmission by telecopier, if the original document is received in the office of the secretary of state within ten days of date of the notification of the rejection.

This rule is intended to implement Iowa Code chapter 490.

721—40.2(490,499,504A) Reinstatement of corporations.

40.2(1) A corporation subject to Iowa Code chapter 490 that was administratively dissolved after July 1, 1992, and prior to July 1, 1993, may reinstate pursuant to section 490.1422 prior to the expiration of two years from the date of the administrative dissolution, or prior to July 1, 1995, whichever occurs first.

40.2(2) A cooperative association subject to Iowa Code chapter 499 that forfeited its corporate rights under section 499.51 prior to July 1, 1993, may reinstate pursuant to section 499.78 prior to July 1, 1995.

40.2(3) A nonprofit corporation subject to Iowa Code chapter 504A, whose certificate of incorporation was canceled pursuant to section 504A.87 prior to July 1, 1993, and whose period for reinstatement had not expired as of July 1, 1993, may apply to the secretary of state for reinstatement pursuant to section 504A.87A prior to the expiration of five years from the date of the cancellation of the certificate of incorporation, or prior to July 1, 1995, whichever occurs first.

This rule is intended to implement Iowa Code sections 490.1422, 504A.87A, and 499.78.

721—40.3(487,490,504A) Names distinguishable upon corporate records.

40.3(1) Except as provided in these rules, a name is considered distinguishable upon the records of the secretary of state if it contains one or more different letters or numerals, or if it contains a different sequence of letters or numerals. A single space used to divide a sequence of letters or numerals into separate words is considered to be a letter for the purpose of this subrule. Differences between singular and plural forms of words are distinguishable. Differences between numerals, Roman numerals, and words representing numerals are distinguishable. The following characters are considered as letters for the purpose of this subrule: $ (dollar sign); + (plus sign); % (percent sign); ¢ (cent sign).

40.3(2) The following words and abbreviations, when positioned as the last word or abbreviation in the corporate name, are not considered in determining whether a name is distinguishable upon the records of the secretary of state:

1. Corporation
2. Company
3. Incorporated
4. Limited
5. Corp.
6. Co.
7. Inc.
8. Ltd.

40.3(3) The presence or absence of the words "limited partnership," or the abbreviation "L.P." in any limited partnership name, when positioned at the end of the name, is not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(4) The presence or absence of the words "professional corporation" or the abbreviation "P.C." in the name of any professional corporation, when positioned at the end of the name, is not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(5) The presence or absence of the words "registered limited liability partnership," or the abbreviation "L.L.P." in any limited liability partnership name, when positioned at the end of the name, is not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(6) The presence or absence of the words "limited liability company," or the abbreviation "L.L.C." or "L.C." in any limited liability company name, when positioned at the end of the name, is not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(7) to **40.3(10)** Reserved.

40.3(11) Differences in punctuation and special characters are not considered in determining whether a name is distinguishable upon the records of the secretary of state. Punctuation and special characters include, but are not limited to:

' (apostrophe)	[(left bracket)
] (right bracket)	: (colon)
, (comma)	— (dash)
- (hyphen)	! (exclamation point)
((left parenthesis)	) (right parenthesis)
. (period)	? (question mark)
' (single quote mark)	" (double quote mark)
; (semicolon)	/ (slash)
* (asterisk)	@ (at sign)
\ (back slash)	{ (left brace)
} (right brace)	^ (caret)
= (equal sign)	> (greater than sign)
< (less than sign)	# (number sign)
~ (tilde)	_ (underline)

40.3(12) Reserved.

40.3(13) Differences in capitalization are not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(14) Differences between an ampersand (&) and the word "and" are not considered in determining whether a name is distinguishable upon the records of the secretary of state.

40.3(15) Reserved.

40.3(16) In determining whether a name is distinguishable upon the records of the secretary of state, names found in the following records will not be considered:

1. Fictitious names.
2. Assumed names of nonprofit corporations.
3. Names of corporations (profit or nonprofit) whose certificates of incorporation have been canceled.
4. Names of corporations (profit or nonprofit) whose certificates of authority have been revoked.
5. Expired or terminated assumed names.
6. Expired name reservations.
7. Expired name registrations.

This rule is intended to implement Iowa Code sections 487.102(4), 490.401, 504A.6, and 504A.67.

721—40.4(490,491,496C,497,498,499,504A) Payment and refund of fees.

40.4(1) The office of secretary of state requires a payment of all fees in full at the time of filing of any corporate document or request for copies.

40.4(2) Filing under any of the corporation or cooperative chapters may be effected only upon the receipt of the correct filing fee. Failure to include the filing fee or partial payment of the filing fee will result in the return of the filing to the sender with instructions to include the correct filing fee.

40.4(3) In the event that a filing fee overpayment is made, the amount in excess of the correct filing fee shall be returned to the filing party. No adjustment is required if the amount of overpayment is one dollar or less.

40.4(4) This subrule implements the pilot project authorized by 2000 Iowa Acts, House File 2545, section 32, for fees required by Iowa Code section 490.122, subsection 1, paragraphs *"a"* and *"s."*

a. The secretary of state may refund payment of the corporate filing fees required pursuant to the provisions of Iowa Code section 490.122, subsection 1, paragraphs *"a"* and *"s,"* if, within five business days from the time the corporate filing is received and date stamped, the entity has not been entered on the records of the secretary of state.

b. To receive a refund under this subrule, the corporate entity must make a written request with the business services division of the secretary of state's office. The written request must specify the reason(s) for the refund and provide evidence of entitlement to the refund.

c. The filing fee shall not be refunded if the corporate filing fails to satisfy all of the filing requirements of Iowa Code chapter 490.

d. The decision of the secretary of state not to issue a refund under this subrule is final and not subject to review pursuant to the provisions of the Iowa administrative procedure Act.

40.4(5) This subrule implements the pilot project authorized by 2000 Iowa Acts, House File 2545, section 32, for fees required by Iowa Code section 504A.85, subsections 1 and 9.

a. The secretary of state may refund payment of the corporate filing fees required pursuant to the provisions of Iowa Code section 504A.85, subsections 1 and 9, if, within five business days from the time the corporate filing is received and date stamped, the entity has not been entered on the records of the secretary of state.

b. To receive a refund under this subrule, the corporate entity must make a written request with the business services division of the secretary of state's office. The written request must specify the reason(s) for the refund and provide evidence of entitlement to the refund.

c. The filing fee shall not be refunded if the corporate filing fails to satisfy all of the filing requirements of Iowa Code chapter 504A.

d. The decision of the secretary of state not to issue a refund under this subrule is final and not subject to review pursuant to the provisions of the Iowa administrative procedure Act.

721—40.5(491,496A,499,504A,548) Document to county recorder.

40.5(1) Any corporate document that is required by law to be filed in the office of the county recorder will be forwarded directly to the office of the county recorder in the county where the corporation's registered office is located.

40.5(2) Reserved.

721—40.6(548) Registration and protection of marks.

40.6(1) *Classification.* The following general classes of goods and services are established, but do not limit or extend the applicant's or registrant's rights, and a single application for registration of a mark may include any or all goods upon which, or services with which, the mark is actually being used comprised in a single class, but in no event shall a single application include goods or services upon which the mark is being used which fall within different classes of goods or services.

The said classes are as follows:

Class	Title	GOODS
1	Raw or partly prepared materials	
2	Receptacles	
3	Baggage, animal equipments, portfolio and pocketbooks	
4	Abrasives and polishing materials	
5	Adhesives	
6	Chemicals and chemical compositions	
7	Cordage	
8	Smokers' articles, not including tobacco products	
9	Explosives, firearms, equipments and projectiles	
10	Fertilizers	
11	Inks and inking materials	
12	Construction materials	
13	Hardware and plumbing and steam-fitting supplies	
14	Metals and metal castings and forgings	
15	Oils and greases	
16	Paints and painters' materials	
17	Tobacco products	
18	Medicines and pharmaceutical preparations	
19	Vehicles	
20	Linoleum and oiled cloth	
21	Electrical apparatus, machines and supplies	
22	Games, toys and sporting goods	
23	Cutlery, machinery and tools, and parts thereof	
24	Laundry appliances and machines	
25	Locks and safes	
26	Measuring and scientific appliances	
27	Horological instruments	

28	Jewelry and precious-metal ware
29	Brooms, brushes and dusters
30	Crockery, earthenware and porcelain
31	Filters and refrigerators
32	Furniture and upholstery
33	Glassware
34	Heating, lighting and ventilating apparatus
35	Belting, hose, machinery packing and nonmetallic tires
36	Musical instruments and supplies
37	Paper and stationery
38	Prints and publications
39	Clothing
40	Fancy goods, furnishings and notions
41	Canes, parasols and umbrellas
42	Knitted, netted and textile fabrics, and substitutes thereof
43	Thread and yarn
44	Dental, medical and surgical appliances
45	Soft drinks and carbonated waters
46	Foods and ingredients of foods
47	Wines
48	Malt beverages and liquors
49	Distilled alcoholic liquors
50	Merchandise not otherwise classified
51	Cosmetics and toilet preparations
52	Detergents and soaps

Class	Title	SERVICES
100	Miscellaneous	
101	Advertising and business	
102	Insurance and financial	
103	Construction and repair	
104	Communication	
105	Transportation and storage	
106	Material treatment	
107	Education and entertainment	

40.6(2) *Assistance in applications.* The secretary of state cannot give legal advice as to the nature and extent of the protection afforded by law nor advise as to the registrability of a specific mark except as questions may arise in connection with pending applications.

40.6(3) *Incomplete or defective applications.* An application will not be filed unless the application and accompanying facsimiles or specimens are in proper form, comply with the statutory requirements and are accompanied by the statutory fee. Specimens which are metal need not be submitted, a facsimile being preferable in order to avoid filing problems. Documents not filed will be returned with a statement of the reasons therefor.

40.6(4) *Registration dates.* The registration date is the date on which the mark is actually posted in the registration indices of the office of the secretary of state, after the application has been examined and found acceptable.

40.6(5) *Form of application.* The application shall be on a current form supplied by the secretary of state, be completed in the English language and plainly written or typed. If the mark or any part thereof is not in the English language, it must be accompanied by a sworn translation.

40.6(6) *Withdrawal of application.* Prior to actual registration of the mark, the applicant, by written request, may withdraw the application.

40.6(7) *Plurality of goods in single application.* A single application may recite a plurality of goods, or a plurality of services, comprised in a single class, provided the particular identification of each of the goods or services be stated and the mark is used or has been actually used on or in connection with all of the goods or in connection with all of the services specified.

40.6(8) *Single class in one application.* A single application to register a mark for both goods and services or for goods or services in different classes will be rejected. Applications must be restricted to goods or services comprised in a single class.

40.6(9) *Conflicts.* Whenever application is made for registration of a mark or trade name which so resembles a mark registered in this state or a mark previously used in this state by another and not abandoned, as to be likely, when applied to the goods or services of the applicant, to cause confusion or mistake or to deceive, a conflict shall be declared to exist and registration denied.

40.6(10) *Conflicts between applications.* Conflicts between pending applications will be resolved on the basis of the claimed date of first use. The secretary of state may require affidavits and other proof of first use.

40.6(11) *Record change on automatic transfer.* In the event of mergers or consolidations of corporations, a certified copy of such documents may be accepted to transfer ownership of marks.

If the name of the owner of record of a mark is changed, and request for a change of the records is made, then written proof of such change can be made by sworn affidavit showing the manner or mode by which the change of ownership was made.

40.6(12) *Change of address.* If the registered owner of a mark changes the address set forth on the registration, then written notice of such change of address must be given to the secretary of state. Such notice must clearly identify the mark or marks involved and must request that the change of address be noted on the records of the registration on file.

These rules are intended to implement Iowa Code chapters 490, 491, 496A, 499, 504A and 548.

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CHAPTER 41
FORMS OF ANNUAL AGRICULTURAL REPORTS
Rescinded IAB 5/31/89, effective 7/19/89

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