State of Iowa

Iowa Administrative Code Supplement

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Acting Administrative Code Editor

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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

Editor's telephone (515) 281-3355 or (515) 281-8157

Accountancy Examining Board[193A]

Replace Chapter 12

Utilities Division[199]

Replace Chapter 22

Historical Division[223]

Replace Chapter 48

Economic Development, Iowa Department of[261]

Replace Analysis
Replace Reserved Chapter 40 with Chapter 40
Remove Reserved Chapters 80 to 100
Insert Chapter 80 and Reserved Chapters 81 to 100

Iowa Finance Authority[265]

Replace Analysis
Replace Chapter 26
Replace Chapter 29
Replace Chapter 32
Insert Chapter 38

Human Services Department[441]

Replace Analysis
Replace Chapter 36
Replace Chapter 75
Replace Chapter 79
Replace Chapter 85
Replace Chapter 108
Replace Chapter 150
Replace Chapter 152
Replace Chapter 156
Replace Chapter 177
Replace Chapter 204

Natural Resource Commission[571]

Replace Analysis
Replace Chapter 23

Replace Chapter 40
Replace Chapter 44
Replace Chapters 46 and 47
Replace Chapter 50
Replace Chapter 53
Replace Chapter 94
Replace Chapter 106
Replace Chapter 108

Professional Licensure Division[645]

Replace Analysis
Replace Chapter 300
Replace Chapters 303 and 304

Medicine Board[653]

Replace Analysis
Replace Chapters 13 and 14

Pharmacy Board[657]

Replace Analysis
Replace Chapter 7
Replace Chapter 10
Insert Reserved Chapters 38 to 99 and Chapter 100

Regents Board[681]

Replace Chapter 4

Labor Services Division[875]

Replace Analysis
Replace Chapter 173
Replace Chapter 177

Index

Replace “S”

CHAPTER 12
FEES

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 5/1/02, see 193A—Chapter 14]

193A—12.1(542) Required fees. The following is a schedule of the fees for examinations, certificates, licenses, permits and renewals adopted by the board:

Initial CPA examination application:	
Paid directly to CPA examination services	not to exceed $1500
Reexamination:	
Paid directly to CPA examination services	not to exceed $1500
Original issuance of CPA certificate or LPA license by examination (fee includes wall certificate)	$100
Original issuance of CPA certificate by reciprocity or substantial equivalency	$100
CPA wall certificate or LPA license issued by reciprocity or substantial equivalency	$50
Replacement of lost or destroyed wall CPA certificate or LPA license	$50
Original issuance of attest qualification	$100
Biennial renewal of CPA certificate or LPA license—active status	$100
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—active status	$25
Biennial renewal of CPA certificate or LPA license—inactive status	$50
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—inactive status	$10
Penalty for failure to comply with continuing education requirements	$50 to $250
Original issuance of firm permit to practice	$50
Annual renewal of firm permit to practice	$50
Reinstatement of lapsed CPA certificate or LPA license	$100 + renewal fee + $25 per month of expired registration
Reinstatement of lapsed firm permit to practice	$100 + renewal fee + $25 per month of expired registration
Interstate Transfer Form	$25

The board has not yet established a fee schedule for annual renewals commencing with certificates and licenses that expire on and after June 30, 2010, and will amend the rules when the revised fee schedule is available.

[**ARC 7715B**, IAB 4/22/09, effective 7/1/09; **ARC 8866B**, IAB 6/30/10, effective 8/4/10; **ARC 8867B**, IAB 6/30/10, effective 8/4/10]

193A—12.2(542) Reinstatement.

12.2(1) *Reinstatement of a lapsed CPA certificate or LPA license.* The fee for the reinstatement of a lapsed CPA certificate or LPA license for applications filed on or after July 1, 2009, is $100 plus the renewal fee plus $25 per month of expired registration up to a maximum of $1,000.

12.2(2) *Reinstatement of lapsed firm permit to practice.* The fee for the reinstatement of a lapsed CPA or LPA firm permit to practice for applications filed on or after July 1, 2009, is $100 plus the renewal fee plus $25 per month of expired registration up to a maximum of $1,000.

[**ARC 7715B**, IAB 4/22/09, effective 7/1/09; **ARC 8867B**, IAB 6/30/10, effective 8/4/10]

193A—12.3(542) Prorating of certain fees.

12.3(1) Fees for issuance of an original certificate or license for less than one year to the biennial renewal date as provided in rule 193A—5.1(542) may be prorated on an annual basis for the remainder of time covered by the certificate or license. For example, if a CPA certificate or LPA license holder applies for the original certificate or license and is required to renew the certificate or license in 12 months or less, the fee would be $50. If the original certificate or license is not scheduled to be renewed for more than 12 months, the fee would be $100.

12.3(2) Fees for the issuance of an original CPA certificate or LPA license, pursuant to rule 193A—5.3(542), or the issuance of an initial permit to practice to a CPA or LPA firm, pursuant to rule 193A—7.1(542), will not be prorated.

[**ARC 7715B**, IAB 4/22/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapter 542.

[Filed and effective September 22, 1975 under ch 17A, C ’73]
[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed emergency 3/9/79—published 4/4/79, effective 3/9/79]
[Filed 2/12/81, Notice 10/29/80—published 3/4/81, effective 4/8/81]
[Filed 2/8/82, Notice 12/9/81—published 3/3/82, effective 4/7/82]
[Filed 6/22/88, Notice 3/9/88—published 7/13/88, effective 8/17/88]
[Filed 3/30/89, Notice 2/8/89—published 4/19/89, effective 5/24/89]
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[Filed ARC 7715B (Notice ARC 7484B, IAB 1/14/09), IAB 4/22/09, effective 7/1/09]
[Filed ARC 8866B (Notice ARC 8616B, IAB 3/24/10), IAB 6/30/10, effective 8/4/10]
[Filed ARC 8867B (Notice ARC 8617B, IAB 3/24/10), IAB 6/30/10, effective 8/4/10]

CHAPTER 22
RATES CHARGED AND SERVICE SUPPLIED BY TELEPHONE UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—22.1(476) General information.

22.1(1) *Application and purpose of rules.* The rules shall apply to any telephone utility operating within the state of Iowa subject to Iowa Code chapter 476, and shall supersede all conflicting rules of any telephone utility which were in force and effect prior to the adoption of their superseding rules. Unless otherwise indicated, "telephone utility" or "utility" shall mean both local exchange utility and alternative operator services company. These rules shall be construed in a manner consistent with their intent:

a. To allow fair competition in the public interest while ensuring the availability of safe and adequate communications service to the public.

b. To provide uniform, reasonable standards for communications service provided by telephone utilities.

c. To ensure that the provision of service of local exchange utilities and the charges of alternative operator services companies for communications service, and regulated services rendered in connection therewith, will be reasonable and just.

d. To ensure that no telephone utility shall unreasonably discriminate among different customers or service categories.

22.1(2) *Waiver and modification.* If unreasonable hardship to a utility or to a customer or user results from the application of any rule herein prescribed, application may be made to the board for the modification of the rule or for temporary or permanent exemption from its requirements.

The adoption of these rules shall in no way preclude the board from altering or amending them, pursuant to statute, or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

22.1(3) *Definitions.* For the administration and interpretation of these rules, the following words and terms shall have the meaning indicated below:

"Active account" refers to a customer who is currently receiving telephone service, or one whose service has been temporarily disconnected (vacation, nonpayment, storm damage, etc.).

"Adjacent exchange service" is local telephone service, including extended area service, provided to a customer via direct facility connection to an exchange contiguous to the exchange in which the customer is located.

"Average busy-season, busy-hour traffic" means the average traffic volume for the busy-season, busy-hours.

"Base rate area" means the developed portion or portions within each exchange service area as set forth in the telephone utility's tariffs, maps or descriptions.

"Board" means the Iowa utilities board.

"Business service" means the service furnished to customers where the use is substantially of a business, professional, institutional, or occupational nature, rather than a social and domestic nature.

"Busy-hour" means the two consecutive half hours during which the greatest volume of traffic is handled in the office.

"Busy-season" means that period of the year during which the greatest volume of traffic is handled in the office.

"Calls" means telephone messages attempted by customers or users.

"Central office" means a unit in a telephone system which provides service to the general public, having the necessary equipment and operating arrangements for terminating and interconnecting customer lines and trunks or trunks only. There may be more than one central office in a building.

"Central office access line" means a circuit extending from the central office equipment to the demarcation point.

"Channel" means an electrical path suitable for the transmission of communications.

"Check of service" or *"service check"* means an examination, test or other method utilized to determine the condition of customer-provided terminal equipment and existing or new inside station wiring.

"Class of service" means the various categories of service generally available to customers, such as business or residence.

"Competitive Local Exchange Carrier" or *"CLEC"* means a utility, other than an incumbent local exchange carrier, that provides local exchange service pursuant to an authorized certificate of public convenience and necessity.

"Customer" means any person, firm, association, corporation, agency of the federal, state or local government, or legal entity responsible by law for payment for communication service from the telephone utility.

"Customer provision" means customer purchase or lease of terminal equipment or inside station wiring from the telephone company or from any other supplier.

"Delinquent or delinquency" means an account for which a bill or payment agreement for regulated services or equipment has not been paid in full on or before the last day for timely payment.

"Demarcation point" means the point of connection provided and maintained by the telephone utility to which inside station wiring becomes dedicated to an individual building or facility. For an individual dwelling, this point of connection will generally be immediately adjacent to, or within 12 inches of, the protector or the dwelling side of the protector. The drop and block, including the protector, will continue to be provided by and remain the property of the telephone utility. In the instance where a physical protector does not exist at the point of cable entrance into the building or facility, the demarcation point is defined as the entrance point of the cable into the building or facility.

"Disconnect" means the disabling of circuitry preventing both outgoing and incoming communications.

"Due date" means the last day for payment without unpaid amounts being subject to a late payment charge or additional collection efforts.

"Exchange" means a unit established by a telephone utility for the administration of communication services.

"Exchange service" means communication service furnished by means of exchange plant and facilities.

"Exchange service area" or *"exchange area"* means the general area in which the telephone utility holds itself out to furnish exchange telephone service.

"Extended area service" means telephone service, furnished at flat rates, between end user customers located within an exchange area and all of the end user customers of an additional exchange area. Extended area service is only for calls both originating and terminating within the defined extended area.

"Foreign exchange service" means exchange service furnished a customer from an exchange other than the exchange regularly serving the area in which the customer is located.

"Former account" refers to a customer whose service has been permanently disconnected, and the final bill either has been paid or has been written off to the reserve for uncollectible accounts.

"Held order for primary service" means an application for establishment of primary service to a local exchange utility using its existing facilities to provide service not filled within five business days of the customer-requested date, or within 15 business days of the customer-requested date, where no facilities are available. During the period a local exchange utility provides equivalent alternative service, the customer's order for primary service shall not be considered a held order.

"Held order for secondary service" means an application for establishment of secondary service to a local exchange utility using its facilities to provide service not filled within 30 business days or the customer-requested date, whichever is later.

"High-volume access service (HVAS)" is any service that results in an increase in total billings for intrastate exchange access for a local exchange utility in excess of 100 percent in less than six months. By way of illustration and not limitation, HVAS typically results in significant increases in interexchange call volumes and can include chat lines, conference bridges, call center operations, help desk provisioning,

or similar operations. These services may be advertised to consumers as being free or for the cost of a long-distance call. The call service operators often provide marketing activities for HVAS in exchange for direct payments, revenue sharing, concessions, or commissions from local service providers.

"Inactive account" refers to a customer whose service has been permanently disconnected and whose account has not been settled either by payment or refund.

"Incumbent Local Exchange Carrier" or *"ILEC"* means a utility, or successor to such utility, that was the historical provider of local exchange service pursuant to an authorized certificate of public convenience and necessity within a specific geographic area described in maps approved by the board as of September 30, 1992.

"Interexchange service" is the provision of intrastate telecommunications services and facilities between local exchanges, and does not include EAS.

"Interexchange utility" means a utility, a resale carrier or other entity that provides intrastate telecommunications services and facilities between exchanges within Iowa, without regard to how such traffic is carried. A local exchange utility that provides exchange service may also be considered an interexchange utility.

"InterLATA toll service" means toll service that originates and terminates between local access transport areas.

"IntraLATA toll service" means toll service that originates and terminates within the same local access transport area.

"Intrastate access services" are services of telephone utilities which provide the capability to deliver intrastate telecommunications services which originate from end-users to interexchange utilities and the capability to deliver intrastate telecommunications services from interexchange utilities to end-users.

"Local exchange service" means telephone service furnished between customers or users located within an exchange area.

"Local exchange utility" means a telephone utility that provides local exchange service under tariff filed with the board. The utility may also provide other services and facilities such as access services.

"Message" means a completed telephone call by a customer or user.

"Message rate service" means service for which the customer charges are based on message units depending in part upon the number of originated local or extended area service messages.

"Outside plant" means the telephone equipment and facilities installed on, along, or under streets, alleys, highways, and private rights-of-way between customer locations, central offices or the central office and customer location.

"Percentage of fill" means the ratio of circuits and equipment in use to the total available multiplied by 100.

"Premises" means the space occupied by an individual customer in a building, in adjoining buildings occupied entirely by that customer, or on contiguous property occupied by the customer separated only by a public thoroughfare, a railroad right-of-way, or a natural barrier.

"Primary service" means the initial access to the public switched network.

"Protector" means a utility-owned electrical device located in the central office, at a customer's premises or anywhere along any telephone facilities which protects both the telephone utility's and the customer's property and facilities from over-voltage and over-current by shunting such excessive voltage and currents to ground.

"Rate zone" means an area other than base rate area within an exchange service area where service generally is furnished at uniform rates without mileage charges.

"Rates" shall mean amounts billed to customers for local exchange service and alternative operator services.

"Rural service" means service in an exchange area outside of a base rate area or generally outside a special rate area.

"Secondary service" means services or facilities not classified as primary service.

"Special rate area" means an area within an exchange where service generally is furnished at uniform rates. Usually this comprises a developed area outside of the base rate area which is also known as a "locality rate area" and separated by some distance from the base rate area.

"Suspend" means temporary disconnection or impairment of service which shall disable either outgoing or incoming communications, or both.

"Switching service" means switching performed for service lines.

"Tariff" means the entire body of rates, classifications, rules, procedures, policies, etc., adopted and filed with the board by a telephone utility, including an alternative operator services company, in fulfilling its role of furnishing communications services.

"Telephone station" means the telephone instrument connected to the network.

"Telephone utility" or *"utility"* means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing communications service to the public for compensation.

"Terminal equipment" means all telephone instruments, including pay telephone equipment, the common equipment of large and small key and PBX systems and other devices and apparatus, and associated wirings, which are intended to be connected electrically, acoustically or inductively to the telecommunication system of the telephone utility.

"Timely payment" is a payment on a customer's account made on or before the due date shown: (1) On a current bill for rates and charges, or (2) by an agreement between the customer and a utility for a series of partial payments to settle a delinquent account.

"Toll connecting trunks" means a general classification of trunks carrying toll traffic and ordinarily extending between a local office and a toll office.

"Toll message" means a message made between different exchange areas for which a charge is made, excluding message rate service charges.

"Toll rate" means the charge prescribed for toll messages, usually based upon the duration of the message, the distance between the exchanges, the day and time of the message and the degree of operator assistance.

"Traffic" means telephone call volume, based on number and duration of calls.

"Traffic grade of service" means the decimal fraction representing the probability of a call being blocked by an all-trunks-busy condition during the average busy-season, busy-hour.

"Trouble report" means any call or written statement from a customer or user of telephone service relating to a physical defect or to difficulty or dissatisfaction with the operation of telephone facilities.

22.1(4) *Abbreviations.*

AOS—Alternative Operator Services

EAS—Extended Area Service

PBX—Private Branch Exchange

22.1(5) *Basic utility obligations.* Each telephone utility shall provide telephone service to the public in its service area in accordance with its rules and tariffs on file with the board. Such service shall normally meet or exceed the standards set forth in these rules governing "Rates Charged and Service Supplied By Telephone Utilities."

22.1(6) *Deregulation actions.*

a. The board, in the dockets shown in subparagraphs (1) to (14), deregulated the following services. Persons interested in determining the precise extent of deregulation in each docket should refer to the board dockets identified in this list. This list is provided for information only. Subsequent orders in these or other dockets may have modified the scope and manner of deregulation. Exclusion of an order or a statutory provision from this list in no way alters the effectiveness of such order or statutory provision.

(1) Inside station wiring including provisioning, repair, and maintenance. This included a revised definition of "demarcation point" in subrule 22.1(3). Docket No. RMU-81-19. Effective October 8, 1982.

(2) Terminal equipment including provision, installation, repair, and maintenance of all customer premises equipment. Docket No. RMU-82-1. Effective May 11, 1983.

(3) Centrex, Hi-Lo Capacity Intraexchange, and Hi Capacity Interexchange and Private Line. Docket No. RPU-84-8. Effective July 1, 1984.

(4) Coin-operated telephones. Pay telephones were determined to be a subset of deregulated terminal equipment. Docket Nos. RMU-85-6 and INU-84-6. Effective September 18, 1985.

(5) Riser cable (or cable for PBXs on the same premises) was found to be an extension of inside wiring. Ownership was transferred from the telephone utility to the premises owner. The telephone utility was compensated for the cable. Docket No. RMU-85-23. Effective April 30, 1986.

(6) Versanet Alarm Services Equipment. The remote module connecting an alarm panel to the local loop was determined to be deregulated terminal equipment. The Versanet equipment monitoring the signal was found to be competitive and deregulated. Docket No. INU-85-5. Effective May 16, 1986.

(7) Mobile telephone and paging services. Docket No. INU-86-2. Effective August 7, 1986.

(8) Billing and collection services (but not the recording function). Docket Nos. RMU-86-16 and INU-86-10. Effective October 15, 1986.

(9) InterLATA Interexchange Message Telecommunications Service (MTS), Wide Area Telecommunications Service (WATS), Channel Service (Private Line), and Custom Network Service (Software Defined Network Service, Megacom Services, Megacom 800 Service, and AT&T Readyline Service). Docket No. INU-88-2. Effective April 5, 1989, and July 19, 1990.

(10) Speed calling. Docket No. INU-88-8. Effective December 22, 1989.

(11) The recording function of billing and collection services. Docket No. INU-88-9. Effective January 9, 1990.

(12) Competitive IntraLATA Interexchange Services, InterLATA and IntraLATA ISDN, Operator Services, Directory Services, and Voice Messaging Service. Docket No. INU-95-3. Effective June 24, 1996.

(13) Local directory assistance. Docket No. INU-00-3. Effective February 23, 2001.

(14) Local exchange services found to be competitive and deregulated in the following exchanges: Armstrong, Coon Rapids, Council Bluffs, Delmar, Forest City, Harlan, Laurens, Lowden, Mapleton, Oxford, Oxford Junction, Primghar, Saint Ansgar, Solon, Spencer, Stacyville, Stanwood, Storm Lake, Tiffin, and Whiting. Docket No. INU-04-1. Effective December 23, 2004.

b. Deregulation resulting from 2005 Iowa Acts, chapter 9, section 1. Effective July 1, 2005, Iowa Code section 476.1D(1) was amended to deregulate the retail rates for most business and residential local exchange services with the exception of single line flat-rated residential and business service rates, at the election of each telephone utility. The affected utilities opted for deregulation as follows:

(1) Approval of Qwest Corporation's replacement tariff. Qwest's replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-167. Effective September 6, 2005.

(2) Approval of Frontier Communications of Iowa, Inc.'s replacement tariff. This replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-181. Effective September 20, 2005.

(3) Approval of Iowa Telecommunications Services, Inc.'s, d/b/a Iowa Telecom, replacement tariff. This replacement tariff removed the rates for most local exchange services, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-182. Effective November 5, 2005.

(4) Single line flat-rated residential and business service rates were found to be competitive and deregulated in the following exchanges: Alta, Belle Plaine, Bennett, Cambridge, Carter Lake, Greene, Grundy Center, Guthrie Center, Hartley, Manning, Marble Rock, Marengo, Onawa, Orange City, Osage, Oyens, Paullina, Reinbeck, Slater, and Wapello. Docket No. INU-05-2. Effective December 5, 2005.

(5) Single line flat-rated residential and business service rates were deregulated pursuant to Iowa Code section 476.1D(1). Docket No. INU-08-1. Effective July 1, 2008.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.2(476) Records and reports.

22.2(1) *Evaluation of records.* Each telephone utility has the obligation to continually study and evaluate its records and reports to ensure that any irregularities in service that may cause customer or user

dissatisfaction or complaint are corrected expeditiously and that all phases of construction, equipment maintenance or operation are satisfactory.

22.2(2) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of Chapter 18 of the board's rules, Utility Records.

Where a telephone utility is operated in conjunction with any other enterprise, suitable records shall be maintained so that the results of the telephone operation may be determined upon reasonable notice and request by the board.

22.2(3) *Tariffs to be filed with the board.* The utility, including an alternative operator services company, shall file its tariff with the board, and shall maintain such tariff filing in a current status. A copy of the same tariff shall also be on file in all business offices of the telephone utility and shall be available for inspection by the public.

The tariff shall be classified, designated, arranged, and submitted so as to conform to the requirements of this chapter or board order. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification, and content of tariffs shall be in accordance with these rules unless otherwise provided.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not file schedules of rates unless required by another rule or by board order. Nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board. Every telephone utility shall make the schedule of its rates readily available to customers on the utility's Web site, if the utility has one, or by mail, upon request.

22.2(4) *Form and identification.* All tariffs shall conform to the following rules.

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½ × 11-inch sheets of white paper equal in durability to 20-pound bond paper with 25 percent cotton or rag content so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency, provided that the rules of the board as to title page; identity of superseding, replacing or revising sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue and effective date; and the words "Filed with the board" shall be applied to modify the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show in the order named:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Telephone Tariff
Filed with
Iowa Utilities Board
_____(date)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on its title page that it is a revision of a tariff on file.

(3) When a revision or amendment is made to a filed tariff, the revision or amendment shall show on each sheet the designation of the original tariff or the number of the immediate preceding revision or amendment which it replaces. (See exhibit A)

(4) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly identify the part eliminated. (See exhibit A)

c. Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

(C)—Changed regulation
(D)—Discontinued rate or regulation
(I)—Increase in rate
(N)—New rate or regulation
(R)—Reduction in rate
(T)—Change in text only

d. All sheets except the title page shall have, in addition to the above-stated requirements, the following further information:

(1) (Name of public utility) Telephone Tariff under which shall be set forth the words "Filed with board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

EXHIBIT A

. . . . . Telephone Tariff
(Name of Company)
Filed with board.

Part No. . . . . .
. . . . . Sheet No. . . . . .
Canceling (or revising). . . . . Sheet No. . . . . .
Amending . . . . . Sheet No. . . . . .

EXAMPLE

Issued . . . . . Effective. . . . . .
(Date) (Date)
By . . . . . .

22.2(5) *Content of tariffs.*

a. A table of contents listing tariff sections in the order in which they appear showing the sheet number of the first page of each rate schedule or other section. In the event the utility filing the tariff elects to segregate a section such as general rules from other sections, it may at its option prepare a separate table of contents or index for each such segregated section.

b. Local exchange utilities shall file a map which shall clearly define the base rate boundary and any rural or special zones that are set forth in the tariff. The boundary line location on such maps shall be delineated from fixed reference points.

c. The period during which the billed amount may be paid before the account becomes delinquent shall be specified. Where net and gross amounts are billed, the difference between net and gross is a late payment charge and the amount shall be specified.

d. Forms of standard contracts required of customers for the various types of service available other than those which are defined elsewhere in the tariff.

e. A designation, by exchange, of the EAS to other exchanges.

f. The list of exchange areas served.

g. Definitions of classes of customers.

h. Extension rules, under which extensions of service will be made, indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included as required in 22.3(6).

i. The type of construction which the utility requires the customer to provide if in excess of the Iowa electrical safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.

j. Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and the terms upon which such construction will be permitted, with

due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.

k. Rules with which prospective customers must comply as a condition of receiving service.

l. Notice by customer required for having service discontinued.

m. Rules covering temporary service.

n. Rules covering the type of equipment which may or may not be connected.

o. Rules on billing periods, bill issuance, notice of delinquency, refusal of service, service disconnection and reconnection and customer account termination for nonpayment of bill.

p. Rescinded IAB 12/21/05, effective 1/25/06.

q. Customer deposit rules which cover when deposits are required, how the amounts of required deposits are calculated, requests for additional deposits, interest on deposits, records maintained, issuance of receipts to customers, replacement of lost receipts, refunds and unclaimed deposit disposition.

r. A separate glossary of all acronyms and trade names used.

s. A general explanation of each regulated service offering available from the utility.

t. to *v.* Rescinded IAB 12/21/05, effective 1/25/06.

22.2(6) *Information to be filed with the board.*

a. Each utility shall file with the board the name, title, address, and telephone number of the person who is authorized to receive, act upon, and respond to communications from the board in connection with the following:

(1) General management duties.

(2) Customer relations (complaints).

(3) Engineering operations.

(4) Outages, including those occurring during nonoffice hours, pursuant to paragraph 22.2(8)*"d."*

b. A copy of a new directory being distributed to customers.

22.2(7) *Universal service certification application.* Rescinded IAB 10/25/06, effective 11/29/06.

22.2(8) *Outage reporting requirements.* Rescinded IAB 2/10/10, effective 3/17/10.

This rule is intended to implement Iowa Code section 476.2.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8516B**, IAB 2/10/10, effective 3/17/10]

199—22.3(476) General service requirements. The requirements of this rule do not apply to intrastate access service.

22.3(1) *Directories.* All directories published after the effective date of these rules shall conform to the following:

a. Telephone directories shall be published not less than annually, except for good cause shown, listing the name, address and telephone number of all customers unless otherwise requested by the customer. A local exchange carrier serving an exchange may choose not to publish a telephone directory if the local exchange carrier makes arrangements for publication in a directory that is commonly available in the local exchange in question.

b. Upon issuance, a copy of each directory shall be distributed without charge to all of the utility's customers locally served by that directory.

c. The year of issue or effective dates shall appear on the front cover and, if space permits, on the binding. Information pertaining to emergency calls, such as for the police and fire departments, for each exchange listed in the directory shall appear conspicuously on the front side of the first page of the directory. The directory shall also show a summary of the names of listed exchanges.

d. The directory shall contain such instructions concerning placing local and long distance calls, calls to repair and information services, and location of telephone company business offices as may be appropriate to the area served by the directory. A statement shall be included that the company will verify the condition of a line if requested by a customer and whether any charge will apply. The directory must indicate how to order 900 and 976 blocking and indicate that the first block is without charge. The directory shall contain descriptions of all current N11 services.

e. Directory assistance or intercept operators shall maintain records of all telephone numbers (except telephone numbers not listed or published at customer request) in the area for which they are responsible for furnishing information service.

f. In the event of an error or omission, in the name or number listing of a customer, that customer's correct name and telephone number shall be furnished to the calling party either upon request to or interception by the telephone company.

g. When additions or changes in plant, records, or operations which will necessitate a large group of number changes are scheduled, reasonable notice shall be given to all customers so affected even though the additions or changes may be coincident with a directory issue.

h. For any exchange in which an extended area call can terminate, the terminating exchange telephone utility shall provide all recently compiled directory listings, except listings for nonpublished or nonlisted customers, to the utility from which the extended area call originates. The telephone utility shall provide the directory listing without charge, within 30 days of receipt of a written request for those listings.

i. In addition to the serving exchange directory listing required under 22.3(1)*"a,"* upon the customer's request, an Iowa customer served by an out-of-state exchange shall be included in the directory list of one contiguous Iowa exchange of the customer's choice. Any charge for such Iowa listing shall be paid by the serving exchange.

22.3(2) *Service check.* Upon the individual customer's request, each telephone utility shall perform a service checkup to the demarcation point, without charge to the customer.

22.3(3) *Class of service.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(4) *Compliance.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(5) *Pay telephone services and facilities.* All telephone utilities shall make available to customers provisions for the interconnection of pay telephone equipment on the same basis as business service. A separate access line shall not be required for pay telephone equipment. Nonrate-regulated telephone utilities shall provide service consistent with this subrule, but the subrule shall not apply to the pricing by nonrate-regulated telephone utilities of access lines to pay telephones.

22.3(6) *Extension plan.* Each utility shall develop a plan, acceptable to the board, for the extensions of facilities, where they are in excess of those included in the regular rates for service and for which the customer shall be required to pay all or part of the cost. The cost required to be paid by the customer shall be the revenue received by the telephone utility for the extension of plant and shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability. This plan must be related to the investment that prudently can be made for the probable revenue. No utility shall make or refuse to make any extensions except as permitted by the approved extension plan.

22.3(7) Reserved.

22.3(8) *Traffic rules.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(9) *"Directory assistance."* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(10) *Nonworking numbers.* All nonworking numbers shall be placed upon an adequate intercept where existing equipment allows.

22.3(11) *Assignment of numbers.*

a. No telephone number shall be reassigned to a different customer within 60 days from the date of permanent disconnect.

b. For customers assigned a new number within the exchange, the former working number intercept shall provide the new number to a calling party for not less than 60 days or until the issuance of a new directory. No new number information shall be provided if the customer so requests.

EXCEPTION: When a change in number is required by a telephone utility due to nonpayment of yellow page advertising, the intercept is not required to volunteer the new number to callers. The new number shall be provided to callers of the directory assistance operator.

c. If the number assigned a customer results in wrong number calls sufficient in volume to be a nuisance, the number shall be changed at no charge.

22.3(12) *Ordering and transferring of service.* The terms and conditions for ordering and transferring local exchange service shall be contained in the telephone utility's tariff.

22.3(13) *Basic local service.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(14) *Adjacent exchange service.* All local exchange utilities shall file tariffs which include provisions which allow customers to establish adjacent exchange service.

a. The tariffs shall require the customer to pay the full cost of establishing and maintaining the adjacent exchange service.

b. In addition, the tariffs may include all or part of the following service provisions:

(1) The subscriber shall subscribe to local exchange service in the primary exchange in addition to the adjacent exchange service.

(2) All toll messages shall be placed through the primary exchange, unless there is a service outage in that exchange.

(3) The primary exchange company shall bill for the adjacent exchange service and make appropriate settlement to the secondary exchange company, unless the primary exchange and the adjacent exchange agree to a different billing arrangement.

(4) Adjacent exchange service shall be restricted to only the residential class of service, unless a waiver is permitted by the board for a particular customer for good cause shown.

(5) Failure of the subscriber to comply with the tariff provisions related to adjacent exchange service shall make the subscriber subject to discontinuance of service after appropriate notice.

c. These adjacent exchange service rules shall not affect the terms under which a customer receives adjacent exchange service, if that customer was receiving adjacent exchange service prior to the effective date of these rules.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.4(476) Customer relations.

22.4(1) *Customer information.*

a. Each utility shall:

(1) Maintain up-to-date maps, plans, or records of its entire exchange systems. These maps shall be available for board examination at a location within Iowa during regular office hours and will be provided to the board upon request. These are not the same maps as the boundary maps described in subrule 22.20(3).

(2) Whenever a residential customer or prospective residential customer requests local exchange service from a utility, and the customer indicates a desire to be informed of the lowest priced service alternatives available for local exchange service, the utility shall inform that customer of the lowest priced alternative available from that utility, based only on monthly recurring rates for flat-rated services, at the relevant location.

(3) Notify customers affected by a change in rates or schedule classification.

(4) Furnish such additional information as the customer may reasonably request.

b. Inquiries for information or complaints to a utility shall be resolved promptly and courteously. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer.

Unless a customer agrees to an alternative form of notice, local exchange utilities shall notify their customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, the service may be subject to state regulation. You may request assistance from the Iowa Utilities Board, 350 Maple Street, Des Moines, Iowa 50319-0069, (515)281-3839 or toll-free 1-877-565-4450 or E-mail iubcustomer@iub.state.ia.us."

The bill insert or notice on the bill will be provided no less than annually. A telephone utility which provides local exchange service and issues an annual directory shall publish the information set forth above in its directory in addition to a mailing.

22.4(2) *Customer deposits.* Each utility may require from any customer or prospective customer a deposit intended to guarantee payment of bills for service based on the customer's credit history. No deposit other than for local exchange service is required to obtain local exchange service. The deposit must reflect the limits as to low-income customers in 199—subparagraph 39.3(2)*"b"*(4).

a. Deposits for local exchange service shall not be more in amount than the maximum charge for two months of local exchange service, or as may reasonably be required by the utility in cases involving service for short periods of time or special occasions. The deposit amounts must also reflect the limits as to low-income customers in 199—subparagraph 39.3(2)*"b"*(4).

b. Interest on customer deposits. Interest on such deposits shall be computed at 4.0 percent per annum, compounded annually. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

c. Each utility shall keep records to show:

(1) The name and address of each depositor.

(2) The amount and date of the deposit.

(3) Each transaction concerning the deposit.

d. Each utility shall issue a receipt of deposit to each customer from whom a deposit is received. An itemized statement on the customer's bill may be considered an appropriate receipt. Each utility shall also provide means whereby a depositor may establish claim if the receipt is lost.

e. The deposit shall be refunded after not more than 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment). The account shall be reviewed after 12 months of service and if the deposit is retained it shall again be reviewed at the end of the utility's accounting year or on the anniversary date of the account.

f. Unclaimed deposits. The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

g. Unclaimed deposits, together with accrued interest, shall be credited to an appropriate account.

h. A new or additional deposit for local exchange service may be required to cover the amount provided in *"a"* above when a deposit has been refunded or the customer's payment history demonstrates a deposit is or continues to be appropriate. Written or verbal notice shall be provided advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of written or verbal notice to comply. The new or additional deposit may be payable electronically or by cash or check at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

i. A customer who fails to pay a new or additional deposit for local exchange service may be disconnected under the provisions of the written notice and 22.4(5).

22.4(3) *Customer billing, timely payment, late payment charges, payment and collection efforts.* Each utility's tariff rules shall comply with these minimum standards.

a. Billing to customers shall be scheduled monthly except upon mutual agreement of the customer and utility. A utility with unusual circumstances may obtain authority from the board for billing at other than monthly intervals.

b. Rescinded IAB 2/6/91, effective 3/13/91.

c. Paper bills shall be issued and delivered via U.S. mail unless the customer agrees to electronic or other billing pursuant to terms specified by tariff or customer agreement. Except as otherwise noted, the requirements of this subrule apply to both paper and electronic bills. The bill form or a bill insert shall provide the following information:

(1) The bill date and the bill due date for local exchange services, service charges, and other telecommunications services.

(2) The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered. For a paper bill, the bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. For an electronic bill, the bill shall be considered rendered to the customer on the date of transmission to the last-known E-mail address or as otherwise defined in an agreement between the customer and utility. If the delivery of a paper bill is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. If a bill cannot be transmitted electronically, the utility shall issue a paper bill. The utility may charge an appropriate amount for the distribution of a paper bill so long as the same amount is discounted should the customer choose electronic billing. When a customer changes from paper billing to electronic billing, the utility shall be allowed one complete billing cycle to make adjustments for electronic billing credits.

(3) Bills to customers shall be rendered regularly and shall contain a clear listing of all charges. A written, itemized listing of the services to which the customer subscribes and the monthly rates for those services shall be provided as part of the initial bill or when service is ordered and subsequently upon reasonable request of the customer.

(4) Each disconnection notice shall state that access to local exchange service shall not be denied for failure to pay for deregulated services.

(5) The requirements of subparagraph (1) above shall not apply to calls billed by interexchange utilities, including AOS companies.

(6) The requirements of subparagraphs (2), (3) and (4) above shall not apply to calls billed to a commercial credit card.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. Unless the terms of a multistate customer contract state otherwise, when the customer makes a partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall first be applied to the undisputed balance for local exchange service. If an amount remains, it may then be applied to other services.

f. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

g. All residential customers shall be permitted to have a last date for timely payment changeable for cause in writing; such as, but not limited to, 15 days following the approximate date each month upon which income is received by the person responsible for payment.

h. Maximum payment required for installation and activation of local exchange service shall comply with the total derived in accord with these rules and the filed tariff.

(1) An applicant for local exchange service, who under the tariff credit rules is required to make a deposit to guarantee payment of bills, may be required to pay the service charges and deposit prior to obtaining service.

(2) The amounts required must comply with 22.4(2), 22.4(5) and 22.4(7).

i. Maximum payments required by an active account or inactive account, for restoration of service of the same class and location as existed prior to disconnection, shall be the total of charges derived for reconnection and must comply with 22.4(2), 22.4(5) and 22.4(7). Only charges specified in the filed tariff shall be applied.

j. The utility may initiate collection efforts with the issuance of a final bill when the termination of service is at the customer's request. For all other bills no collection effort other than rendering of the bill shall be undertaken until the delinquency date.

k. Undercharges. The time period for which a utility may back bill a customer for undercharges shall not exceed five years unless otherwise ordered by the board.

l. Overcharges. The time period for which the utility is required to refund or credit the customer's bill shall not exceed five years unless otherwise ordered by the board. Refunds to current customers may be in the form of bill credits, unless the refund exceeds $50 and the customer requests a refund in the same manner by which the bill was originally paid. Refunds to former customers may be made in the same manner by which the bill was originally paid. Refunds for local exchange service may not be applied to unpaid amounts for unregulated services.

22.4(4) *Customer complaints.*

a. Complaints concerning the charges, practices, facilities, or service of the utility shall be investigated promptly and thoroughly. The utility shall keep a record of such complaint showing the name and address of the complainant, the date and nature of the complaint, its disposition, and all other pertinent facts dealing with the complaint, which will enable the utility to review and analyze its procedure and actions. The records maintained by the utility under this rule shall be available for a period of two years for inspection by the board or its staff upon request.

b. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of all customer complaints.

c. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

d. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

22.4(5) *Refusal or disconnection of service.* Notice of a pending disconnection shall be rendered and local exchange service shall be refused or disconnected as set forth in the tariff. The notice of pending disconnection required by these rules shall be a written notice setting forth the reason for the notice, and the final date by which the account is to be settled or specific action taken.

The notice shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The final date shall be not less than five days after the notice is rendered.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for refusal or disconnection of service. This notice shall include a toll-free or collect number where a utility representative qualified to provide additional information about the disconnection can be reached. The notice shall also state the final date by which the account is to be settled or other specific action taken. In determining the final date, the days of notice for the causes shall be concurrent.

Service may be refused or disconnected for any of the reasons listed below. Unless otherwise stated, the customer shall be provided notice of the pending disconnection and the rule violation which necessitates disconnection. Furthermore, unless otherwise stated, the customer shall be allowed a reasonable time in which to comply with the rule before service is disconnected. Except as provided in 22.4(5)*"a," "b," "c," "d,"* and *"e,"* no service shall be disconnected on the day preceding or the day on which the utility's local business office or local authorized agent is closed. Service may be refused or disconnected:

a. Without notice in the event of a condition on the customer's premises determined by the utility to be hazardous.

b. Without notice in the event of customer's use in such a manner as to adversely affect the utility's equipment or the utility's service to others.

c. Without notice in the event of tampering with equipment furnished and owned by the utility.

d. Without notice in the event of unauthorized use.

e. For violation of or noncompliance with the utility's rules on file with the board, the requirements of municipal ordinances or law pertaining to the service.

f. For failure of the customer or prospective customer to furnish service equipment, permits, certificates or rights-of-way specified to be furnished in the utility's rules filed with the board as conditions for obtaining service, or for the withdrawal of that same equipment or the termination of those permissions or rights, or for the failure of the customer or prospective customer to fulfill the contractual obligations imposed upon the customer as conditions of obtaining service by a contract filed with and subject to the regulatory authority of the board.

g. For failure of the customer to permit the utility reasonable access to its equipment.

h. For nonpayment of bill or deposit, except as restricted by 22.4(7), provided that the utility has made a reasonable attempt to effect collection and:

(1) Has provided the customer with 5 days' prior written notice with respect to an unpaid bill and 12 days' prior written notice with respect to an unpaid deposit, as required by this rule; disconnection may take place prior to the expiration of the 5-day unpaid bill notice period if the utility determines, from verifiable data, that usage during the 5-day notice period is so abnormally high that a risk of irreparable revenue loss is created.

(2) Is prepared to reconnect the same day if disconnection is scheduled for a weekend, holiday or after 2 p.m.

(3) In the event of a dispute concerning the bill, the telephone company may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill. Following payment of the undisputed amount, efforts to resolve the complaint, using complaint procedures in the company's tariff, shall continue and for not less than 45 days after the rendering of the disputed bill, the service shall not be disconnected for nonpayment of the disputed amount. The 45 days may be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board.

22.4(6) *Medical emergency.* Disconnection of a residential customer shall be postponed 30 days if an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered would present an especial danger to the health of any permanent resident of the premises. Indicators of an especial danger to health include, but are not limited to: age; infirmity; mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstance which may indicate a severe or hazardous health situation. The telephone utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered, and a statement that the person is a resident of the premises in question. Initial verification may be by telephone, but the telephone utility may require a written verification within 5 days of the verification of the especial health danger by the physician or a public health official, including the name of the person endangered and a statement that the person is a resident of the premises in question. If the service has been disconnected within 14 days prior to verification of illness for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not make payment during the 30-day period, the service is then subject to disconnection pursuant to subrule 22.4(5).

22.4(7) *Insufficient reasons for refusal, suspension, or discontinuance of service.* The following shall not constitute sufficient cause for refusal, suspension, or discontinuance of local exchange service to a present or prospective customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for terminal equipment, inside station wiring or other merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Permitting another occupant of the premises access to the telephone utility service when that other occupant owed an uncollectible bill for service rendered at a different location.

f. Failure to pay for yellow page advertising.

g. Failure to pay for deregulated services other than local exchange service.

22.4(8) *Temporary service.* When the utility renders temporary service to a customer, it may require that the customer bear all the cost of installing and removing the service facilities in excess of any salvage realized.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.5(476) Telephone utility service standards.

22.5(1) *Requirement for good engineering practice.* The telephone plant of the utility shall be designed, constructed, installed, maintained and operated subject to the provisions of the Iowa electrical safety code as defined in 199 IAC Chapter 25 and in accordance with accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

22.5(2) *Adequacy of service.*

a. Each local exchange utility and alternative operator services company shall employ prudent management and engineering practices so that sufficient equipment and adequate personnel are available at all times, including average busy-hour of the busy-season.

b. Each local exchange utility and alternative operator services company shall conduct traffic studies, employ reasonable procedures for forecasting future service demand, and maintain records necessary to demonstrate to the board that sufficient equipment is in use and that an adequate operating force is provided.

c. Each utility shall employ adequate procedures for assignment of facilities. The assignment record shall be kept up-to-date and checked periodically to determine if adjustments are necessary to maintain proper balance in all trunk and equipment groups. The records shall be available for review by the board upon request.

d. The criteria established in these rules define a minimal acceptable standard for the most basic elements of telecommunications service. The rules do not include all criteria and they do not establish the most desirable service level for any basic element. If a specific element is not covered, the provider must meet generally accepted industry standards for that element. Total service must also meet generally accepted industry standards.

e. The standards within these rules establish the minimum acceptable quality of service under normal operating conditions. They do not establish a level of performance to be achieved during the periods of emergency, catastrophe affecting large numbers of customers, nor do they apply to extraordinary or abnormal conditions of operation, such as those resulting from work stoppage, civil unrest, or other events.

22.5(3) *Central office requirements.*

a. Each local exchange utility shall employ appropriate procedures to determine the adequacy of central office equipment. Sufficient central office capacity and equipment shall be provided to meet the following minimum requirements during average busy-season, busy-hour:

(1) Dial tone within three seconds for 98 percent of call attempts on the switched network.

(2) Complete dialing of called numbers on at least 97 percent of telephone calls without encountering an all-trunks-busy condition within the central office.

(3) At least 98 percent of all correctly dialed interoffice local calls shall not encounter an all-trunks-busy condition.

(4) At least 98 percent of all correctly dialed calls offered to any trunk group within an EAS calling area will not encounter an all-trunks-busy condition.

b. Each local exchange utility shall engineer all central office equipment using sound engineering practice, consistent with the practices of the telephone industry. All new central offices shall be engineered on a terminal-per-station basis.

c. Rescinded IAB 6/3/09, effective 7/8/09.

d. Each central office shall be provided with alarms on a 24-hour basis to indicate improper functioning of equipment. All alarms shall be transmitted to an alarm center or to a location that will receive and respond to the alarm condition as set forth in the Utilities Emergency/Disaster Plan on a

24-hour, seven-day-a-week basis. All alarms and alarm sensors must be tested and reported internally on a regular basis, not to exceed six months.

22.5(4) *Telecommunication circuits.* All circuits shall be properly constructed and maintained to ensure quality service.

22.5(5) *Interexchange trunks.* Trunks for extended area service shall be provided so that at least 98 percent of telephone calls will not encounter an all-trunks-busy condition.

22.5(6) *Loop transmission requirements.* Local exchange utilities shall furnish and maintain adequate plant, equipment, and facilities to provide satisfactory transmission of communications between users in their service areas. Transmission shall be at adequate volume levels and free of excessive distortion. Levels of noise and cross talk shall be such as not to impair communications.

22.5(7) *Minimum transmission objectives.*

a. The transmission objectives set forth are based upon the use of standard telephone stations connected to a 48-volt dial central office, and measured at a frequency of 1,000 hertz.

b. Lines shall have a loop resistance not exceeding the operating design of the associated central office equipment, unless long line adapters and amplifiers or special equipment are used.

c. All loop measurements shall be taken across tip and ring and to ground at the demarcation point excluding all inside wiring and terminal equipment.

(1) Loop current shall be acceptable above 20 mA.

(2) Circuit loss shall be measured at 1004 KHz at 0 dBm from the central office. The acceptable level shall be 0 to—8 dBm with a maintenance margin not to exceed 8.5 dB.

(3) Circuit noise shall be measured on a quiet (balanced) termination from the central office. The acceptable level shall be less than 20 dBrnC, the marginal level between 20 and 30 dBrnC, and unacceptable above 30 dBrnC.

(4) Power influence level shall be acceptable from 0 to 80 dBrnC, marginal from 80 to 90 dBrnC, and unacceptable above 90 dBrnC. Although the communication utility has the requirement to meet this objective, the communication and electric utilities shall cooperate in mitigating the effects of AC power induction.

d. Whenever feasible, the overall transmission loss, including terminating equipment, on intertandem trunks should be 6 dB for an all digital connection. Overall transmission loss, including terminating equipment on intertandem trunks should not exceed 9 dB for a composite digital and analog connection. This measurement shall be taken at 1004 Hz.

(1) The transmission objectives set forth are based upon measurements at the customer's network interface device with the customer premise disconnected.

(2) The transmission loss as set forth means the loss that occurs in a telecommunication connection measured in decibels (dB) at 1004 Hz exclusive of rest pads, impedance matching coils used for measuring and similar devices.

(3) A customer line shall, in general, have loop resistance not exceeding the operating design of the associated central office equipment. Amplifiers and long line adapters may be used to extend the central office design limits.

(4) A minimum line current of 20 mA DC is acceptable.

(5) The customer line (loop) shall be designed for a maximum loss of 8.0 dB at 1004 Hz to be measured from the customer demarcation to the central office one milliwatt test tone supply.

(6) The actual measured loss of the customer loop shall not exceed 9.0 dB from the customer demarcation to the central office one milliwatt test tone supply. A loss greater than 9.0 dB is unacceptable, requiring immediate action.

(7) Circuit noise is to be measured on a quiet termination from the central office. The acceptable level is not to exceed 20 dBrnC. The marginal level is between 20 dBrnC and 30 dBrnC. Any measurement exceeding 30 dBrnC is unacceptable, requiring immediate action.

22.5(8) *Joint use.* Where joint construction is mutually agreed upon, it shall be subject to the provisions of the Iowa electrical safety code and the requirement for good engineering practice found in subrule 22.5(1).

22.5(9) *Provisions for testing.* Each telephone utility shall provide or have access to test facilities which will enable it to determine the operating and transmission capabilities of circuit and switching equipment, either for routine maintenance or for fault location.

22.5(10) *Operator-assisted calls.* These operator services rules shall apply to all local exchange utilities, interexchange utilities, and alternative operator services companies which provide operator services.

a. All communications between customers must be considered as confidential in nature. The provider shall take reasonable action to minimize the potential access of other entities to those communications. Operators or employees of the provider must not listen to any conversation between customers except when an operating necessity. Operators shall not repeat or divulge the nature of any local or long distance conversation, nor divulge any information inadvertently overheard. Providers will be held responsible for strict compliance with this rule by their employees or other entities which perform this service for the provider.

b. Suitable rules and instructions shall be adopted by each provider and followed by employees or other entities employed by the provider governing the language and operating methods to be used by operators during assistance to customers. Any required call timing for regulated operator-assisted calls shall accurately record when the customer-requested connection is established and when it is terminated.

c. Each provider offering operator assistance to the public shall provide a service that can answer 90 percent of directory, intercept, toll, and local assistance calls within ten seconds. On the average, calls shall be answered within five seconds.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. An answer shall mean that the operator is ready to accept information necessary to process the call. An acknowledgment that the customer is waiting on the line shall not constitute an answer.

f. All operators receiving 0 - and 911 calls shall be capable of connecting calls to appropriate emergency services at all hours. All operator services providers shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

g. Third-party billing from identified public pay telephones and reverse charges from all telephones will be allowed:

(1) If the person or device answering responds positively that the charges will be accepted, with the provision that remaining on the line does not constitute a positive response;

(2) On reverse charges, when it is apparent the voice on the answering machine is the caller's voice; and

(3) On a third-party billing, when it is apparent the voice on the answering machine at the billing number is the caller's voice.

22.5(11) *Maintenance of plant and equipment.*

a. Each telephone utility shall adopt and pursue a program of periodic inspection, testing, and preventive maintenance aimed at achieving efficient operation of its system to permit the rendering of safe, adequate and continuous service at all times.

b. Maintenance shall include keeping all plant and equipment in a good state of repair consistent with safe and adequate service performance. Broken, damaged or deteriorated parts which are no longer serviceable shall be repaired or replaced. Adjustable apparatus and equipment shall be readjusted promptly when found by preventive routines or fault location tests to be in unsatisfactory operating condition. Electrical faults, such as leakage or poor insulation, noise induction, cross talk, or poor transmission characteristics shall be promptly corrected to the extent practicable within the design capability of the plant affected when located or identified.

c. In all exchanges, periodic leakage tests shall be made on all circuits by use of proper instruments to determine that sufficient insulation is being maintained and further to discover any substantial change in insulation values which might cause future service difficulties. Loop resistance and transmission tests should be made on local circuits when transmission is poor, in an endeavor to locate the source of trouble.

d. Central office batteries shall be replaced when required to maintain good telephone service.

e. Central office equipment shall be inspected and routinely tested at regular intervals, and any necessary repairs, adjustments or replacements made to ensure the proper functioning of switching equipment.

f. All regulated outside plant facilities shall be properly maintained including replacement of equipment when broken, damaged, or when necessary for good transmission.

g. Records of various tests and inspections shall be kept on file in the office of the telephone utility for a minimum of one year. These records shall show the line or regulated equipment tested or inspected, the reason for the test, the general conditions under which the test was made, the general result of the test, and any corrections made.

22.5(12) Reserved.

22.5(13) *Terminating access blocking.* Rescinded IAB 12/21/05, effective 1/25/06.

22.5(14) *Information service access blocking.* Each local exchange utility shall include in its tariff on file with the board a provision giving its subscribers the option of blocking access to all 900 and 976 prefix numbers, without charge for the first block.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.6(476) Standards of quality of service. The local exchange utility using its facilities to provide primary service will measure its service connection, held order, and service interruption performance monthly according to subrules 22.6(1), 22.6(2), and 22.6(3). Records of the measurements and any summaries thereof, by individual wire centers, will be provided upon request of the board. Records of these measurements will be retained by the utility for two years.

22.6(1) *Service connection.* Each local exchange utility using its facilities to provide service shall make all reasonable efforts to maintain a five-business-day standard for primary connection service or within the customer-requested service connection date. All reasonable efforts to maintain the above standard shall be measured by the following:

a. Eighty-five percent of all customers provided service within five business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

b. Ninety-five percent of all customers provided service within ten business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

c. Ninety-nine percent of all customers provided service within 30 business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

22.6(2) *Held orders.*

a. During such period of time as a local exchange utility using its facilities to provide service may not be able to supply primary telephone service to prospective customers within five business days after the date applicant desires service, the telephone utility shall keep a record, by exchanges, showing the name and address of each applicant for service, the date of application, the date that service was requested, and the class of service applied for, together with the reason for the inability to provide new service to the applicant.

b. When, because of a shortage of facilities, a utility is unable to supply primary telephone service on the date requested by applicants, first priority shall be given to furnishing those services which are essential to public health and safety. In cases of prolonged shortage or other emergency, the board may require establishment of a priority plan, subject to its approval for clearing held orders, and may request periodic reports concerning the progress being made.

c. When the local exchange utility using its facilities to provide service fails to provide primary local exchange service to any customer requesting service within 15 business days, the local exchange utility shall provide the customer with an alternative form of service until primary local exchange service can be provided. The alternative form of service provided shall be wireless telephone service unless the customer agrees otherwise.

d. If an alternative form of primary service is provided, the local exchange utility is authorized to charge the customer the regular rates (if applicable) for the alternative primary service ordered, if such rates are less than the regulated rate for primary local exchange service. Otherwise, the customer will be charged the regulated rate for primary local exchange service. Where an alternative form of service is impossible to provide, the facilities-based local exchange utility shall waive all usual installation charges and, once primary local exchange service is provided, shall credit the customer's account in an amount equal to the pro-rata monthly primary local exchange charge for each day service was not provided.

22.6(3) *Service interruption.*

a. Each telephone utility using its facilities to provide primary service shall make all reasonable efforts to prevent interruptions of service. When interruptions are reported or found by the utility to occur, the utility shall reestablish service with the shortest possible delay. Priority shall be given to a residential customer who states that telephone service is essential due to an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered. All reasonable efforts shall be measured by the following:

(1) Eighty-five percent of all out-of-service trouble reports cleared within 24 hours. Compliance will be measured based on a three-month rolling average.

(2) Ninety-five percent of all out-of-service trouble reports cleared within 48 hours. Compliance will be measured based on a three-month rolling average.

(3) One hundred percent of all out-of-service trouble reports cleared within 72 hours.

(4) The response time for all utilities responsible to test and attempt to correct any interexchange trunk problem, except a total outage, shall be within 24 hours after the problem is reported. If the problem is not corrected within that time, the utility responsible for doing so shall keep all other affected telephone utilities advised as to the current status on a daily basis. For a total outage, the response time shall be immediate.

b. Arrangements shall be made to have adequate personnel and equipment available to receive and record trouble reports and also to clear trouble of an emergency nature at all times.

c. Calls directed to the published telephone numbers for service repair or the business offices of the telephone utility shall be acknowledge within 20 seconds for 85 percent of all such calls and within 40 seconds for 100 percent of all such calls.

d. If a customer's service must be interrupted due to maintenance, the utility shall notify the affected customer, in advance, if possible. The company shall perform the work to minimize inconvenience to the customer and strive to avoid interruptions when there is conversation on the line.

e. Each telephone utility shall keep a written record showing all interruptions affecting service in a major portion of an exchange area for a minimum of six years. This record shall show the date, time, duration, time cleared and extent and cause of the interruption. This record shall be available to the board upon request.

f. Whenever a trouble report is received, a record shall be made by the company and if repeated within a 30-day period by the same customer, the case shall be referred to an individual for permanent correction.

g. When a customer's service is reported or is found to be out of order, it shall be restored as promptly as possible.

h. Each local exchange utility using its facilities to provide service shall maintain its network to reasonably minimize customer trouble reports. The rate of customer trouble reports on the company side of the demarcation point will not exceed four per 100 access lines per month per wire center.

i. When a subscriber's service is interrupted and remains out of service for more than 24 consecutive hours after being reported to the local exchange company or being found by the company to be out of order, whichever occurs first, the company shall make appropriate adjustments to the subscriber's account. This rule does not apply if the outage occurs as a result of:

(1) A negligent or willful act on the part of the subscriber;

(2) A malfunction of subscriber-owned telephone equipment;

(3) Disasters or acts of God; or

(4) The inability of the company to gain access to the subscriber's premises.

The adjustment, either a direct payment or a bill credit, shall be the proportionate part of the monthly charges for all services and facilities rendered inoperative during the interruption. The adjustment shall begin with the hour of the report or discovery of the interruption. Adjustments not in dispute shall be rendered within two billing periods after the billing period in which the interruption occurred.

22.6(4) *Repair—missed appointments.* When a utility makes an appointment for installation or repair within a given range of time, and misses that appointment by over an hour, the customer will receive one month's primary local service free of charge. This is applicable to each missed appointment.

22.6(5) *Emergency operation.*

a. Each telephone utility shall make reasonable provisions to meet emergencies resulting from failures of power service, climate control, sudden and prolonged increases in traffic, illness of operators, or from fire, explosion, water, storm, or acts of God, and each telephone utility shall inform affected employees, at regular intervals not to exceed one year, of procedures to be followed in the event of emergency in order to prevent or mitigate interruption or impairment of telephone service.

b. All central offices shall have adequate provision for emergency power. Each central office shall contain a minimum of two hours of battery reserve. For offices without permanently installed emergency power facilities, there shall be access to a mobile power unit with enough capacity to carry the load which can be delivered on reasonably short notice and which can be readily connected.

c. An auxiliary power unit shall be permanently installed in all toll centers and at all exchanges exceeding 4,000 access lines.

d. Each local exchange utility shall maintain and make available for board inspection, its current plans for emergency operations, including the names and telephone numbers of the local exchange utility's disaster services coordinator and alternates.

22.6(6) *Business offices.*

a. Each local exchange utility shall have one or more business offices or customer service centers staffed to provide customer access in person or by telephone to qualified personnel, including supervisory personnel where warranted, to provide information relating to services and rates, accept and process applications for service, explain charges on customers' bills, adjust charges made in error, and, generally, to act as representatives of the local exchange utility. If one business office serves several exchanges, toll-free calling from those exchanges to that office shall be provided.

b. Upon the closing of any local exchange utility's public business office, the company must provide to the board, in writing, at least 30 days prior to the closing of the office the following information:

(1) The exchange(s) and communities affected by the closing;

(2) The date of the closing;

(3) A listing of other methods and facility locations available for payment of subscribers' bills in the affected exchanges; and

(4) A listing of other methods and locations available for obtaining public business office services.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.7(476) Safety.

22.7(1) *Protective measures.*

a. Each utility shall exercise reasonable care to reduce the hazards to which its employees, its customers or users and the general public may be subjected.

b. The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

c. Each utility shall maintain a summary of all reportable accidents arising from its operations.

22.7(2) *Safety program.* Each utility shall adopt and execute a safety program, fitted to the size and type of its operations. As a minimum, the safety program should:

a. Require employees to use suitable tools and equipment in order that they may perform their work in a safe manner.

b. Instruct employees in safe methods of performing their work.

c. Instruct employees who, in the course of their work, are subject to the hazard of electrical shock, asphyxiation or drowning, in accepted methods of artificial respiration.

199—22.8(476) Nontoll interexchange trunking service (EAS) survey procedure.

22.8(1) *General information.*

a. The nontoll interexchange trunking service (EAS) survey procedures shall be followed by all telephone companies subject to the service jurisdiction of this board. The procedures in 22.8(2) and 22.8(3) shall be followed to establish EAS. The procedures in 22.8(4) and 22.8(5) shall be followed in order to discontinue EAS. There is no need to follow these procedures if there will be no rate increase associated with new EAS.

b. At all stages of this procedure the information required to be supplied to customers shall be sufficient to explain the required items to the customers, yet the information shall be in a form which is sufficiently brief not to confuse the customers or discourage the customers from completing the survey.

c. Whenever an EAS survey is conducted, the company shall mail to each customer account (primary service listing) a survey letter explaining the purpose of the survey, and a postage-paid, company-addressed return postcard on which the customer can indicate the customer's preference.

d. The company shall provide the board, for its approval, a copy of the proposed text and format of the customer letter and ballot survey card. The board may require alterations or corrections before permission is granted to proceed with the actual survey of the customers.

22.8(2) *Procedures and requirements for establishing EAS studies.*

a. The initiative for EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer shall include address and telephone number. Initiative for EAS may also come from the company or the board.

b. If the requirements of 22.8(2), paragraph *"a,"* are fulfilled, a point-to-point usage study should be used to determine if sufficient community interest exists. There should be an average of five or more calls per customer per month and more than 50 percent of the customers making at least two toll calls per month. If these basic criteria are not met, the request will be dismissed without further proceedings.

c. If the provisions of 22.8(2), paragraph *"b,"* have been met, additional customer calling studies, cost and revenue studies including loss of toll revenues may be conducted, and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

d. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(3) *Procedures and requirements for customer survey to establish EAS.*

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

(1) An explanation of the purpose of the survey.

(2) A statement which identifies by class and grade of service the existing rate, the amount of rate increase and the new rate associated with the addition of the proposed EAS.

(3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the proposal before further action will be taken.

(4) A statement indicating the proposed date when service would be established which shall not be more than two years from the survey ballot return date, unless the delay is granted by the board due to the facility considerations.

(5) The date by which the ballot must be returned to be considered shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

(1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.

(2) A place for the customer to indicate whether customer favors or is opposed to the establishment of EAS.

(3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years the ballots may be destroyed; however, the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers in an exchange vote in favor of EAS to another exchange but concurrence in two-way EAS is not received from that second exchange then consideration may be given to one-way EAS. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include information concerning lack of concurrence on two-way service by the neighboring exchange and that another survey is being taken to determine interest in one-way calling.

22.8(4) *Procedures and requirements for discontinuing EAS.*

a. The initiative to discontinue EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer must include address and telephone number. Initiative to discontinue EAS may also come from the company or the board.

b. Customer calling studies, cost and revenue studies may be conducted and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

c. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(5) *Procedures and requirements for customer survey to discontinue EAS.*

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

(1) An explanation of the purpose of the survey.

(2) A statement which identifies by class and grade of service the amount of rate decrease, if any, and the new rates associated with the proposed discontinuance of EAS.

(3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the discontinuance proposal before further action will be taken.

(4) A statement indicating the proposed date when service would be discontinued (which shall not be more than six months from the survey ballot return date).

(5) The date by which the ballots must be returned to be considered. This return date shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

(1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.

(2) A place for the customer to indicate whether customer favors or is opposed to the discontinuance of EAS.

(3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years, the ballot may be destroyed; provided, however, a record showing the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers approve discontinuance of two-way EAS to another exchange and concurrence in that discontinuance cannot be obtained from the customers of the second exchange, consideration may be given to continuance of one-way EAS by that second exchange. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include a statement indicating that the neighboring exchange or its customers have voted to discontinue two-way EAS and that this survey is being taken to determine interest in one-way calling.

199—22.9(476) Terminal equipment. Terminal equipment is deregulated. Customers may secure terminal equipment through any provider.

199—22.10(476) Unfair practices. All unfair or deceptive practices related to customer provision of equipment are prohibited. Any failure to provide information to customers or to deal with customers who provide their own terminal equipment or inside station wiring or an alteration of the charges for or availability of equipment or services on that ground, unless specifically authorized by board order or rule and by the utility's tariff, shall constitute unfair or deceptive practices. In cases of equipment in compliance with Federal Communications Commission registration requirements, telephone utility personnel are prohibited from making any statement, express or implied, to, or which will reach, a customer or prospective customer that terminal equipment in compliance with Federal Communications Commission registration requirements cannot properly be attached to the telephone network. This does not apply to good-faith efforts to amend the Federal Communications Commission requirements.

The listing of unfair practices in this rule shall not limit the types of acts which may be found to be unfair nor shall those listed be used to establish decisional criteria operating to exempt any act otherwise unfair from the intent of this rule.

199—22.11(476) Inside station wiring standards.

22.11(1) *Construction by user limitation.* A user shall not be allowed to construct inside station wiring from a demarcation point or between two or more buildings on the same premises to obtain service from an exchange other than that by which the user would normally be served, excluding users being provided adjacent exchange service or foreign exchange service as provided in a company's tariff. Existing inside wiring obtaining local exchange service within another exchange boundary shall be disconnected by the user within ten days after receipt of written notification from the local exchange company.

22.11(2) *Standards applicable to inside station wiring.* The following technical standards must be complied with:

a. Applicable registration standards promulgated by the Federal Communications Commission.

b. 47 CFR Part 68.

c. Applicable national, state or local building and electrical codes, including National Electrical Code, as defined in 199—subrule 25.2(5); and accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and safety of persons and property.

199—22.12(476) Contents of tariff filings proposing rates.

22.12(1) *Construction of rule.* This rule shall be construed in a manner consistent with its purpose to expedite informed consideration of tariff filings proposing rates by ensuring the availability of relevant information on a standardized basis. Unless a waiver is granted prior to filing, this rule shall apply to all tariff filings by rate-regulated telephone utilities proposing rates, except the tariff filings of AOS utilities that propose rates at or below the corresponding rates for similar services of utilities whose rates have been approved by the board in a rate case or set in a market determined by the board to be competitive.

22.12(2) *Cost studies to be filed.* Rescinded IAB 6/3/09, effective 7/8/09.

22.12(3) *Specification of cost methodologies.* Rescinded IAB 6/3/09, effective 7/8/09.

22.12(4) Rescinded, effective June 10, 1987.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.13(476) Methodology for determining costs to serve. Rescinded IAB 6/3/09, effective 7/8/09.

199—22.14(476) Intrastate access charge application, tariff procedures, and rates.

22.14(1) *Application of intrastate access charges.*

a. Intrastate access charges shall apply to all intrastate access services rendered to interexchange utilities. Intrastate access charges shall not apply to EAS traffic. In the case of resale of services of interexchange utilities, access charges shall apply as follows:

(1) The interexchange utilities shall be billed as if no resale were involved.

(2) The resale carrier shall be billed only for access services not already billed to the underlying interexchange utility.

(3) Specific billing treatment and administration shall be provided pursuant to tariff.

b. Except as provided in 22.14(1)*"b"*(3), no person shall make any communication of the type and nature transmitted by telephone utilities, between exchanges located within Iowa, over any system or facilities, which are or can be connected by any means to the intrastate telephone network, and uses exchange utility facilities, unless the person shall pay to the exchange utility or utilities which provide service to the exchange where the communication is originated and the exchange where it is terminated, in lieu of the carrier common line charge, a charge in the amount of $25 per month per circuit that is capable of interconnection. However, if the person provides actual access minutes to the exchange utility, the charge shall be the charge per access minute or fraction thereof provided in 22.14(2)*"d"*(1), not to exceed $25 per line per month. The charge shall apply in all exchanges. However, if the person attests in writing that its facility cannot interconnect and is not interconnected with the exchange in question, the person will not be subject to the charge in that exchange.

(1) In the event that a communication is made without compliance with this rule, the telephone utility or utilities serving the person shall terminate telephone service after notice pursuant to subrule 22.4(5). The utility shall not reinstate service until the board orders the utility to restore service. The board shall order service to be restored when it has reasonable assurance that the person will comply with this rule.

(2) In any action concerning this rule, the burden of proof shall be upon the person making intrastate communications.

(3) This rule shall be inapplicable to:

1. Communications made by a person using facilities or services of telephone utilities to which an intrastate carrier common line charge applies pursuant to 22.14(3)*"a."*

2. Administrative communications made by or to a telephone utility.

22.14(2) *Filing of intrastate access service tariffs.*

a. Tariffs providing for intrastate access services shall be filed with the board by a telephone utility which provides such services. Iowa intrastate access service tariffs of rate-regulated utilities shall be based only on Iowa intrastate costs. Unless otherwise provided, the filings are subject to the applicable rules of the board.

b. A non-rate-regulated local exchange utility in its general tariff may concur in the intrastate access tariff filed by another non-rate-regulated local exchange utility.

(1) Alternatively, a non-rate-regulated local exchange utility may voluntarily elect to join another nonrate regulated local exchange utility or utilities in forming an association of local exchange utilities. The association may file intrastate access service tariffs. A utility in its general tariff can concur in the association tariffs.

(2) All elements of the filings, under rule 22.14(476) including access service rate elements, shall be subject to review and approval by the board.

c. Rescinded IAB 2/7/90, effective 3/14/90.

d. All intrastate access service tariffs shall incorporate the following:

(1) Carrier common line charge. The rate for the intrastate carrier common line charge shall be three cents per access minute or fraction thereof for both originating and terminating segments of the communication, unless a different rate is required by numbered paragraphs "1" and "2." The carrier common line charge shall be assessed to exchange access made by any interexchange telephone utility, including resale carriers. In lieu of this charge, interconnected private systems shall pay for access as provided in 22.14(1)*"b."*

1. Incumbent local exchange carrier intrastate access service tariffs shall include the carrier common line charges approved by the board.

2. A competitive local exchange carrier that concurs with the Iowa Telephone Association (ITA) Access Service Tariff No. 1 and that offers service in exchanges where the incumbent local exchange carrier's intrastate access rate is lower than the ITA access rate shall deduct the carrier common line charge from its intrastate access service tariff.

(2) End-user charge. No intrastate end-user charge shall be assessed.

(3) Universal service fund. No universal service fund shall be established.

(4) Transitional and premium rates. There shall be no discounted transitional rate elements applied in Iowa except as otherwise specifically set forth in these rules.

(5) Recording function of billing and collections. The intrastate access service tariffs shall include the rate to be charged for performing the recording function associated with billing and collections.

(6) A telephone utility may, pursuant to tariff, bill for access on the basis of assumed minutes of use where measurement is not practical. However, if the interexchange utility provides actual minutes of use to the billing utility, the actual minutes shall be used.

(7) In the absence of a waiver granted by the board, local exchange utilities shall allow any interexchange utility the option to use its own facilities that were in service on March 19, 1992, to provide local access transport service to terminate its own traffic to the local exchange utility. The interexchange utility may use its facilities in the manner and to a meet point agreed upon by the local exchange utility and the interexchange utility as of March 19, 1992. Changes mutually agreeable to the local exchange utility and the interexchange utility after that date also shall be recognized in allowing the interexchange utility to use its own local access transport facilities to terminate its own traffic. Recognition under this rule will also be extended to improvements by an interexchange utility that provided all the transport facilities to an exchange on March 19, 1992, whether the improvements were mutually agreeable or not, unless the improvements are inconsistent with an agreement between the interexchange utility and the local exchange utility.

(8) A provision prohibiting the application of association access service rates to HVAS traffic.

e. A local exchange utility that is adding a new HVAS customer or otherwise reasonably anticipates an HVAS situation shall provide notice of the situation, the telephone numbers that will be assigned to the HVAS customer (if applicable), and the expected date service to the HVAS customer will be initiated, if applicable. Notice may be sent to each interexchange utility that paid for intrastate access services from the local exchange carrier in the preceding 12 months; to any carrier with whom the local exchange carrier exchanged traffic in the preceding 12 months; and to all other local exchange carriers authorized to provide service in the subject exchange, by a method calculated to provide adequate notice. Any interexchange utility may request negotiations concerning the access rates applicable to calls to or from the HVAS customer.

Any interexchange utility that believes a situation has occurred or is occurring that does not specifically meet the HVAS threshold requirements defined in subrule 22.1(3), but which raises the same general concerns and issues as an HVAS situation, may file a complaint with the board pursuant to these rules.

A local exchange utility that experiences an increase in intrastate access billings that qualifies as an HVAS situation, but did not add a new HVAS customer or otherwise anticipate the situation, shall notify interexchange utilities of the HVAS situation at the earliest reasonable opportunity, as described in the preceding paragraph. Any interexchange utility may request negotiations concerning whether the local exchange utility's access rates, as a whole or for HVAS only, should be changed to reflect the increased access traffic.

When a utility requests negotiations concerning intrastate access services, the parties shall negotiate in good faith to achieve reasonable terms and procedures for the exchange of traffic. No access charges shall apply to the HVAS traffic until an access tariff for HVAS is accepted for filing by the board and has become effective. At any time that any party believes negotiations will not be successful, any party may file a written complaint with the board pursuant to Iowa Code section 476.11. In any such proceeding, the board will consider setting the rate for access services for HVAS traffic based upon the incremental

cost of providing HVAS, although any other relevant evidence may also be considered. The incremental cost will not include marketing or other payments made to HVAS customers. The resulting rates for access services may include a range of rates based upon the volume of access traffic or other relevant factors. Any negotiations pursuant to this paragraph shall conclude within 60 days. After 60 days, a party to the negotiations may petition the board to extend the period of negotiations or may petition the board to set a hearing pursuant to 199—paragraph 7.4(10)*"d."*

22.14(3) Rescinded, IAB 9/21/88, effective 10/26/88.

22.14(4) *Notice of intrastate access service tariffs.*

a. Each telephone utility that files new or changed tariffs relating to access charges, access service, or the recording function associated with billing and collection for access services shall give written notice of the new or changed tariffs to the utility's interexchange utility access customers, the board, and the consumer advocate. Notice shall be given on or before the date of filing of the tariff. The notice shall consist of: the file date, the proposed effective date, a description of the proposed changes, and the tariff section number where the service description is located. If two or more local exchange utilities concur in a single tariff filing, the local exchange utilities may send a joint written notice to the board, consumer advocate, and the interexchange utilities.

b. The board shall not approve any new or changed tariff described in paragraph *"a"* until after the period for resistance provided in subrule 22.14(5), paragraph *"a."*

22.14(5) *Resistance to intrastate access service tariffs.*

a. If an interexchange utility affected by an access service filing or the consumer advocate desires to file a resistance to a proposed new or changed access service tariff, it shall file its resistance within 14 days after the filing of the proposed tariff. The interexchange utility shall send a copy of the resistance to all telephone utilities filing or concurring in the proposed tariff.

b. After receipt of a timely resistance, the board may:

(1) Deny the resistance if it does not on its face present a material issue of adjudicative fact or the board determines the resistance to be frivolous or otherwise without merit and allows the tariff to go into effect by order or by operation of law; or

(2) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate informal complaint proceedings; or

(3) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate contested case proceedings; or

(4) Reject the tariff, stating the grounds for rejection.

c. The interexchange utility or the consumer advocate shall have the burden to support its resistance.

d. If contested case proceedings are initiated upon resistance filed by an interexchange utility, the interexchange utility shall pay the expenses reasonably attributable to the proceeding unless the interexchange utility is the successful party as determined by the board.

22.14(6) *Access charge rules to prevail.* The provisions of rule 22.14(476) shall be determinative of the procedures relating to intrastate access service tariffs and shall prevail over all inconsistent rules.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.15(476) Interexchange utility service and access.

22.15(1) *Interexchange utility service.* An interexchange utility may provide interexchange service by complying with the laws of this state and the rules of this board. Any company or other entity accessing local exchange facilities or services in order to provide interexchange communication services to the public shall be considered to be an interexchange utility and subject to the rules herein, unless otherwise exempted. Such utilities are required to file a registration form, reports, and other items and are subject to service standards as specified in utilities division rules, unless otherwise exempted.

22.15(2) *Interexchange utility intrastate access.* Intrastate access to local exchange services or facilities may be obtained by an interexchange utility by ordering and paying for such intrastate access pursuant to the applicable tariff filed by the exchange utility in question, or as otherwise provided by agreement between the parties.

22.15(3) *Willful violation.* Any interexchange utility which the board finds has willfully failed to pay the intrastate carrier common line charge as specified in 22.14(3)*"a"* shall be in willful violation of board rules.
[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.16(476) Discontinuance of service. No local exchange utility or interexchange utility may discontinue providing intrastate service to any local exchange or part of a local exchange except in the case of emergency, nonpayment of account, or violation of rules and regulations; except as provided below.

22.16(1) Prior to discontinuing service, the utility shall file with the board and consumer advocate a notice of intent to discontinue service at least 90 days prior to the proposed date of discontinuance. However, if the utility shows it has no customers for the service it proposes to discontinue, the utility need only file such notice 30 days prior to discontinuance.

22.16(2) The notice of discontinuance of service shall include the following:

1. The name and address of the utility involved;
2. The name, title, and address of the person to whom correspondence concerning the notice should be directed;
3. A description of the nature of and reasons for the proposed discontinuance;
4. Identification of the exchange or part of exchange involved and the date on which the utility desires to discontinue service;
5. A description of the area affected and an assessment of the impact on present and future public convenience and necessity of such discontinuance, including the name and address of any other utility currently or potentially providing the same or substitute service to the area;
6. A description of the service proposed to be discontinued, of the existing service available to the exchange or part of exchange involved, and of the service of the applying utility or others which would remain in the event approval is granted.

22.16(3) If after 30 days of the filing of such notice, no action is taken by the board, the discontinuance may take place as proposed.

22.16(4) The board, on its own motion or at the request of the consumer advocate or affected customer, may hold a hearing on such discontinuance.

199—22.17(476) Resale of service.

22.17(1) Any landlord, owner, tenant association, or otherwise affiliated group shall be permitted to provide communications services within or between one or more buildings with a community of interest. The provision of this service will be treated as a deregulated service, if the following requirements are met:

a. No person within a building or facility providing resale services shall be denied access to the local exchange carrier. The local exchange carrier shall provide service at normal tariffed rates to the point of demarcation. The end-user shall be responsible for service beyond that point. However, no person shall unreasonably inhibit the end-user's access to the local exchange carrier.

b. Telephone rates charged to resale providers of communications services under this rule shall be made on the same basis as business service.

c. "Community of interest" will normally be indicated by joint or common ownership, but any other relevant factors may be considered.

22.17(2) Any interested person may request formal complaint proceedings with respect to any existing or proposed resale arrangement under this rule. Complaints may concern, but are not limited to:

a. Whether the reseller is, in fact, a local exchange carrier in its own right, as demonstrated by limitations on access to the original local exchange carrier, the geographical area of the offering, or other relevant factors; and

b. Whether the reseller is allowing access to the local exchange carrier on reasonable terms.

199—22.18(476) Low-income connection assistance program. Rescinded IAB 12/31/97, effective 1/1/98.

199—22.19(476) Alternative operator services.

22.19(1) *Definitions.* The definitions found in Iowa Code section 476.91 apply to this rule.

22.19(2) *Tariffs.* Alternative operator service companies must provide service pursuant to board-approved tariffs covering both rates and service.

22.19(3) *Blocking.* AOS companies shall not block the completion of calls which would allow the caller to reach a long distance telephone company different from the AOS company. All AOS company contracts with contracting entities must prohibit call blocking by the contracting entity. The contracting entity shall not violate that contract provision.

22.19(4) *Posting.* Contracting entities must post on or in close proximity to all telephones served by an AOS company the following information:

a. The name and address of the AOS company;

b. A customer service number for receipt of further service and billing information; and

c. Dialing directions to the AOS operator for specific rate information.

Contracts between AOS companies and contracting entities shall contain provisions for posting the information. The AOS companies also are responsible for the form of the posting and shall make reasonable efforts to ensure implementation, both initially and on an updated basis.

22.19(5) *Oral identification.* All AOS companies shall announce to the end-user customer the name of the provider carrying the call and shall include a sufficient delay period to permit the caller to terminate the call or advise the operator to transfer the call to the end-user customer's preferred carrier before billing begins.

22.19(6) *Billing.* All AOS company bills to end-user customers shall comply with the following requirements, in addition to the requirements of subrule 22.4(3):

a. All calls, except those billed to commercial credit cards, shall be itemized and identified separately on the bill. All calls will be rated solely from the end-user customer's point of origin to point of termination.

b. All bills, except those for calls billed to commercial credit cards, shall be rendered within 60 days of the provision of the service.

c. All charges for the use of a telephone instrument shall be shown separately for each call, except for calls billed to a commercial credit card.

22.19(7) *Emergency calls.* All AOS companies shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

199—22.20(476) Service territories. Service territories are defined by the telephone exchange area boundary maps on file with the Iowa utilities board. The maps will be available for viewing at the board's office during regular business hours and copies are available at the cost of reproduction. This rule does not apply to resale of local telephone service pursuant to rule 22.17(476).

22.20(1) *Issuance of certificates of authority to utilities on or prior to September 30, 1992.* The initial nonexclusive certificate of authority will be issued by the board on or before September 30, 1992, to each land-line telephone utility providing local telecommunications service in Iowa. The certificate will authorize service within the territory as shown by boundary maps in effect on January 1, 1992, but will reference and include modifications approved by the board prior to the issuance of the certificate. The certificate will be in the form of an order issued by the board and may be modified only by subsequent board orders.

If a utility disputes the boundary identified in the January 1, 1992, maps or in a certificate, it may file an objection with the board. After notice to interested persons and an opportunity for hearing, the board will determine the boundary.

22.20(2) *Procedures to revise maps and modify certificates.* All territory in the state shall be served by a local exchange utility and inappropriate overlaps of service territories are to be avoided.

a. When the board, after informal investigation, determines a significant gap or overlap exists on the maps on file defining service territories, affected utilities and interested persons, including affected customers, will be notified. The board will direct the affected utilities to file a proposed boundary within 30 days, if the utilities can agree.

b. The boundary filing must include the name of each affected customer and justification for the proposed boundary, including a detailed statement of why the proposal is in the public interest. Prior to filing with the board, the serving utilities must notify interested persons of a convenient location where they can view the current and proposed maps, or copies of the maps covering their location must be mailed to them. The notice shall state the nature of the boundary filing and that any objections must be mailed to the board postmarked within 14 days of the mailing of the notice by the utility. The utility's filing shall also include a copy of the notice and the date on which the notice was mailed to customers.

c. Upon board approval of the proposed boundary, the affected utilities shall file revised maps which comply with subrule 22.20(3) and, upon approval of the maps, the board will modify the certificates.

d. If the utilities cannot agree on the boundary, or if an interested person timely mails material objections to the proposed boundary, the board will resolve the issues in contested case proceedings to revise the maps and modify the certificates after notice of the proceedings to all affected utilities and interested persons.

e. A voluntary modification petition filed jointly by all affected utilities pursuant to 1992 Iowa Acts, Senate File 511, shall contain the information required in 22.20(2)*"b."* The notice and hearing requirements in 22.20(2)*"b"* through *"d"* shall be observed in voluntary modification proceedings.

f. A post-January 1, 1992, map will not be effective in defining a utility's service territory until approved by the board.

22.20(3) *Map specifications.* All ILECs shall have on file with the board maps which identify their exchanges and both internal exchange boundaries where the utility's own exchanges abut and ultimate boundaries where the utility's exchanges abut other utilities. A CLEC shall either file its own exchange boundary map or adopt the exchange boundary map filed by the ILEC serving that exchange.

a. Each utility's maps shall be on a scale of one inch to the mile. They shall include information equivalent to the county maps which are available from the Iowa department of transportation, showing all roads, railroads, waterways, plus township and range lines outside the municipalities. A larger scale shall be used where necessary to clarify areas. All map details shall be clean-cut and readable.

(1) Each filed map shall clearly show the ultimate utility boundary line; this line shall be periodically marked with the letter "U." Exchange boundaries where the utility's own exchanges abut shall be periodically marked with the letter "E." Ultimate and exchange boundary lines shall be drawn on a section, half-section, or quarter-section line. If not, the distance from a section line or other fixed reference point shall be clearly noted. When using a fixed reference point, measurement shall always be from the center of the fixed point.

(2) The map shall also identify the utility serving each contiguous exchange. The utility names shall be placed about the exterior of the ultimate boundary. The points at which the adjacent exchange meets the ultimate boundary will be marked with arrows.

(3) Plant facilities shall not be shown on the boundary map. Approximate service locations may be shown but are not required.

(4) The name of the utility filing the map shall be placed in the upper right corner of the map. This will be followed by the names of each exchange shown on the map and served by that utility. The last item will be the date the map is filed and the proposed effective date, which will be 30 days after the filing date unless the board sets a different date.

b. If requested by the board, a legal description shall be filed to clarify an ambiguous boundary between utilities. The legal description shall conform with the standards set in Iowa Code section 114A.9.

22.20(4) *Subsequent certificates.* Any legal entity which desires to serve all or a portion of a territory which is currently assigned to another land-line utility may petition for a new certificate or a certificate modification depending upon whether the utility already has a certificate to serve. After notice to affected utilities and opportunity for hearing, the board will determine whether the new certificate or certificate

modification will promote the public convenience and necessity. If the new or modified certificate is granted, the result may be two or more utilities serving all or a portion of an assigned territory.

22.20(5) *Certificate revocation.* Any five subscribers or potential subscribers, an interexchange utility, or consumer advocate upon filing a sworn statement showing a generalized pattern of inadequate telephone service or facilities may petition the board to begin formal certificate revocation proceedings against a local exchange utility. For the purposes of this rule, inadequate telephone service or facilities may include the failure to bill high-volume intrastate access (HVAS) charges in a manner consistent with the requirements of rule 199—22.14(476). While similar in nature to a complaint filed under rule 199—6.2(476), a petition under this rule shall be addressed by the board under the following procedure and not the procedure found in 199—Chapter 6.

a. Upon receiving a petition, the board will make an informal preliminary investigation into the adequacy of the service and facilities provided by a local exchange utility. The board also may begin an informal preliminary investigation on its own motion at any time.

b. Prior to beginning formal revocation proceedings under 1992 Iowa Acts, Senate File 511, the board will provide notice to the utility of any alleged inadequacies in its service. The utility may admit or deny the allegations. If admitted, the utility will have a reasonable time to eliminate the inadequacies. If denied, the utility will have the opportunity to refute the allegations in contested case proceedings after mailed notice and an opportunity to intervene for the utility's affected customers.

c. If the board does not issue the notice of alleged inadequacies to the utility as provided in 22.20(2)*"b"* within 60 days after the filing of the petition, the petition will be deemed denied.

d. If the board finds significant inadequacies in service or facilities in any certificate revocation contested case, the utility will be allowed a reasonable time to eliminate the inadequacies.

e. If the utility fails to eliminate significant inadequacies in service or facilities within a reasonable time, the board, after mailed notice to all parties in the contested case, or to affected customers if the utility admitted the inadequacies, and after an opportunity for hearing, may revoke or condition the certificate as provided in 1992 Iowa Acts, Senate File 511.

f. Proceedings under this subrule may be combined with proceedings under subrule 22.20(4), or similar certification proceedings initiated on the board's own motion, to consider an appropriate replacement utility simultaneously with the revocation case.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.21(476) Toll dialing patterns. All local exchange utilities shall use the dialing pattern, 0 or 1 plus ten digits, for all toll calls either within a single numbering plan area or from one numbering plan area to another.

199—22.22(476) Requests for interconnection negotiations. Rescinded IAB 8/28/96, effective 8/2/96.

199—22.23(476) Unauthorized changes in telephone service.

22.23(1) *Definitions.* As used in this rule, unless the context otherwise requires:

"Change in service" means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, and includes the addition or deletion of a telecommunications service for which a separate charge is made to a customer account.

"Consumer" means a person other than a service provider who uses a telecommunications service.

"Cramming" means the addition or deletion of a product or service for which a separate charge is made to a telecommunication customer's account without the verified consent of the affected customer. Cramming does not include the addition of extended area service to a customer account pursuant to board rules, even if an additional charge is made. Cramming does not include telecommunications services that are initiated or requested by the customer, including dial-around services such as "10-10-XXX," directory assistance, operator-assisted calls, acceptance of collect calls, and other casual calling by the customer.

"Customer" means the person other than a service provider whose name appears on the account and others authorized by that named person to make changes to the account.

"Executing service provider" means, with respect to any change in telecommunications service, a service provider who executes an order for a change in service received from another service provider or from its own customer.

"Jamming" means the addition of a preferred carrier freeze to a customer's account without the verified consent of the customer.

"Letter of agency" means a written document complying with the requirements of 199 IAC 22.23(2)*"b."*

"Preferred carrier freeze" means the limitation of a customer's preferred carrier choices so as to prevent any change in preferred service provider for one or more services unless the customer gives the service provider from which the freeze was requested the customer's express consent.

"Service provider" means a person providing a telecommunications service, not including commercial mobile radio service.

"Slamming" means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, without the verified consent of the customer. "Slamming" does not include the designation of a new provider of a telecommunications service to a customer made pursuant to the sale or transfer of another carrier's customer base, provided that the designation meets the requirements of 199 IAC 22.23(2)*"e."*

"Soft slam" means an unauthorized change in service by a service provider that uses the carrier identification code (CIC) of another service provider, typically through the purchase of wholesale services for resale.

"Submitting service provider" means a service provider who requests another service provider to execute a change in service.

"Telecommunications service" means a local exchange or long distance telephone service other than commercial mobile radio service.

"Verified consent" means verification of a customer's authorization for a change in service.

22.23(2) *Prohibition of unauthorized changes in telecommunications service.* Unauthorized changes in telecommunications service, including but not limited to cramming and slamming, are prohibited.

a. Verification required. No service provider shall submit a preferred carrier change order or other change in service order to another service provider unless and until the change has first been confirmed in accordance with one of the following procedures:

(1) The service provider has obtained the customer's written authorization in a form that meets the requirements of 199 IAC 22.23(2)*"b"*; or

(2) The service provider has obtained the customer's electronic authorization to submit the preferred carrier change order. Such authorization must be placed from the telephone number(s) on which the preferred carrier is to be changed and must confirm the information required in subparagraph (1) above. Service providers electing to confirm sales electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred carrier change, including automatically recording the originating automatic numbering identification; or

(3) An appropriately qualified independent third party has obtained the customer's oral authorization to submit the preferred carrier change order that confirms and includes appropriate verification data. The independent third party must not be owned, managed, controlled, or directed by the service provider or the service provider's marketing agent; must not have any financial incentive to confirm preferred carrier change orders for the service provider or the service provider's marketing agent; and must operate in a location physically separate from the service provider or the service provider's marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred carrier change; or

(4) The local service provider may change the preferred service provider, for customer-originated changes to existing accounts only, through maintenance of sufficient internal records to establish a valid customer request for the change in service. At a minimum, any such internal records must include the date and time of the customer's request and adequate verification of the identification of the person

requesting the change in service. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer's request for the change in service.

All verifications shall be maintained for at least two years from the date the change in service is implemented. Verification of service freezes shall be maintained for as long as the preferred carrier freeze is in effect.

(5) For other changes in service resulting in additional charges to existing accounts only, a service provider shall establish a valid customer request for the change in service through maintenance of sufficient internal records. At a minimum, any such internal records must include the date and time of the customer's request and adequate verification under the circumstances of the identification of the person requesting the change in service. Any of the three verification methods in 22.23(2)*"a"*(1) to (3) will also be acceptable. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer's request for the change in service. Where the additional charge is for one or more specific telephone calls, examples of internal records a carrier may submit include call records showing the origin, date, time, destination, and duration of the calls, and any other data the carrier relies on to show the calls were made or accepted by the customer, along with an explanation of the records and data.

b. Letter of agency form and content.

(1) A service provider may use a letter of agency to obtain written authorization or verification of a customer's request to change the customer's preferred service provider selection. A letter of agency that does not conform with this subrule is invalid for purposes of this rule.

(2) The letter of agency shall be a separate document (or an easily separable document) containing only the authorizing language described in subparagraph (5) below having the sole purpose of authorizing a service provider to initiate a preferred service provider change. The letter of agency must be signed and dated by the customer to the telephone line(s) requesting the preferred service provider change.

(3) The letter of agency shall not be combined on the same document with inducements of any kind.

(4) Notwithstanding subparagraphs (2) and (3) above, the letter of agency may be combined with checks that contain only the required letter of agency language as prescribed in subparagraph (5) below and the necessary information to make the check a negotiable instrument. The letter of agency check shall not contain any promotional language or material. The letter of agency check shall contain, in easily readable, boldface type on the front of the check, a notice that the customer is authorizing a preferred service provider change by signing the check. The letter of agency language shall be placed near the signature line on the back of the check.

(5) At a minimum, the letter of agency must be printed with a type of sufficient size and readable type to be clearly legible and must contain clear and unambiguous language that confirms:

1. The customer's billing name and address and each telephone number to be covered by the preferred service provider change order;

2. The decision to change the preferred service provider from the current service provider to the soliciting service provider;

3. That the customer designates [insert the name of the submitting service provider] to act as the customer's agent for the preferred service provider change;

4. That the customer understands that only one service provider may be designated as the customer's interstate or interLATA preferred interexchange service provider for any one telephone number. To the extent that a jurisdiction allows the selection of additional preferred service providers (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, or international interexchange), the letter of agency must contain separate statements regarding those choices, although a separate letter of agency for each choice is not necessary; and

5. That the customer understands that any preferred service provider selection the customer chooses may involve a charge to the customer for changing the customer's preferred service provider.

(6) Any service provider designated in a letter of agency as a preferred service provider must be the service provider directly setting the rates for the customer.

(7) Letters of agency shall not suggest or require that a customer take some action in order to retain the customer's current service provider.

(8) If any portion of a letter of agency is translated into another language, then all portions of the letter of agency must be translated into that language. Every letter of agency must be translated into the same language as any promotional materials, oral descriptions or instructions provided with the letter of agency.

c. Customer notification. Every change in service shall be followed by a written notification to the affected customer to inform the customer of the change. Such notice shall be provided within 30 days of the effective date of the change. Such notice may include, but is not limited to, a conspicuous written statement on the customer's bill, a separate mailing to the customer's billing address, or a separate written statement included with the customer's bill. Each such statement shall clearly and conspicuously identify the change in service, any associated charges or fees, the name of the service provider associated with the change, and a toll-free number by which the customer may inquire about or dispute any provision in the statement.

d. Preferred carrier freezes.

(1) A preferred service provider freeze (or freeze) prevents a change in a customer's preferred service provider selection unless the customer gives the service provider from whom the freeze was requested express consent. All local exchange service providers who offer preferred service provider freezes must comply with the provisions of this subrule.

(2) All local exchange service providers who offer preferred service provider freezes shall offer freezes on a nondiscriminatory basis to all customers, regardless of the customer's service provider selections.

(3) Preferred service provider freeze procedures, including any solicitation, must clearly distinguish among telecommunications services (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, and international toll) subject to a preferred service provider freeze. The service provider offering the freeze must obtain separate authorization for each service for which a preferred service provider freeze is requested.

(4) Solicitation and imposition of preferred service provider freezes.

1. All solicitation and other materials provided by a service provider regarding preferred service provider freezes must include:

- An explanation, in clear and neutral language, of what a preferred service provider freeze is and what services may be subject to a freeze;
- A description of the specific procedures necessary to lift a preferred service provider freeze; an explanation that these steps are in addition to the verification requirements in 22.23(2)*"a"* and 22.23(2)*"b"* for changing a customer's preferred service provider selections; and an explanation that the customer will be unable to make a change in service provider selection unless the freeze is lifted; and
- An explanation of any charges associated with the preferred carrier freeze.

2. No local exchange carrier shall implement a preferred service provider freeze unless the customer's request to impose a freeze has first been confirmed in accordance with one of the following procedures:

- The local exchange carrier has obtained the customer's written and signed authorization in a form that meets the requirements of 22.23(2)*"d"*(4)"3"; or
- The local exchange carrier has obtained the customer's electronic authorization, placed from the telephone number(s) on which the preferred service provider freeze is to be imposed, to impose a preferred service provider freeze. The electronic authorization shall confirm appropriate verification data and the information required in 22.23(2)*"d"*(4)"3." Service providers electing to confirm preferred service provider freeze orders electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred service provider freeze request, including automatically recording the originating automatic numbering identification; or
- An appropriately qualified independent third party has obtained the customer's oral authorization to submit the preferred service provider freeze and confirmed the appropriate verification

data and the information required in 22.23(2)*"d"*(4)"3." The independent third party must not be owned, managed, or directly controlled by the service provider or the service provider's marketing agent; must not have any financial incentive to confirm preferred service provider freeze requests for the service provider or the service provider's marketing agent; and must operate in a location physically separate from the service provider or the service provider's marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred service provider freeze.

3. A local exchange service provider may accept a written and signed authorization to impose a freeze on the customer's preferred service provider selection. Written authorization that does not conform with this subrule is invalid and may not be used to impose a preferred service provider freeze.

- The written authorization shall comply with 22.23(2)*"b"*(5)"2" and "3" and 22.23(2)*"b"*(8) concerning the form and content for letters of agency.
- At a minimum, the written authorization must be printed with a readable type of sufficient size to be clearly legible and must contain clear and unambiguous language that confirms: (1) the customer's billing name and address and the telephone number(s) to be covered by the preferred service provider freeze; (2) the decision to place a preferred service provider freeze on the telephone number(s) and particular service(s). To the extent that a jurisdiction allows the imposition of preferred service provider freezes on additional preferred service provider selections (e.g., for local exchange, intraLATA/intrastate toll, interLATA/interstate toll service, and international toll), the authorization must contain separate statements regarding the particular selections to be frozen; (3) that the customer understands that the customer will be unable to make a change in service provider selection unless the preferred service provider freeze is lifted; and (4) that the customer understands that any preferred carrier freeze may involve a charge to the customer.

(5) All local exchange service providers who offer preferred service provider freezes must, at a minimum, offer customers the following procedures for lifting a preferred service provider freeze:

1. A local exchange service provider administering a preferred service provider freeze must accept a customer's written and signed authorization stating the intention to lift a preferred service provider freeze; and

2. A local exchange service provider administering a preferred service provider freeze must accept a customer's oral authorization stating the intention to lift a preferred carrier freeze and must offer a mechanism that allows a submitting service provider to conduct a three-way conference call with the service provider administering the freeze and the customer in order to lift a freeze. When engaged in oral authorization to lift a preferred service provider freeze, the service provider administering the freeze shall confirm appropriate verification data and the customer's intent to lift the particular freeze.

e. Procedures in the event of sale or transfer of customer base. A telecommunications carrier may acquire, through a sale or transfer, either part or all of another telecommunications carrier's customer base without obtaining each customer's authorization in accordance with 199 IAC 22.23(2)*"a,"* provided that the acquiring carrier complies with the following procedures. A telecommunications carrier may not use these procedures for any fraudulent purpose, including any attempt to avoid liability for violations under 199 IAC 22.23(2)*"a."*

(1) No later than 30 days before the planned transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall file with the board a letter notifying the board of the transfer and providing the names of the parties to the transaction, the types of telecommunications services to be provided to the affected customers, and the date of the transfer of the customer base to the acquiring carrier. In the letter, the acquiring carrier also shall certify compliance with the requirement to provide advance customer notice in accordance with 199 IAC 22.23(2)*"e"*(3) and with the obligations specified in that notice. In addition, the acquiring carrier shall attach a copy of the notice sent to the affected customers.

(2) If, subsequent to the filing of the letter of notification with the board required by 199 IAC 22.23(2)*"e"*(1), any material changes to the required information develop, the acquiring carrier shall file written notification of these changes with the board no more than 10 days after the transfer date

announced in the prior notification. The board may require the acquiring carrier to send an additional notice to the affected customers regarding such material changes.

(3) Not later than 30 days before the transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall provide written notice to each affected customer. The acquiring carrier must fulfill the obligations set forth in the written notice. The written notice must inform the customer of the following:

1. The date on which the acquiring carrier will become the customer's new provider of telecommunications service;

2. The rates, terms, and conditions of the service(s) to be provided by the acquiring carrier upon the customer's transfer to the acquiring carrier, and the means by which the acquiring carrier will notify the customer of any change(s) to these rates, terms, and conditions;

3. The acquiring carrier will be responsible for any carrier change charges associated with the transfer;

4. The customer's right to select a different preferred carrier for the telecommunications service(s) at issue, if an alternative carrier is available;

5. All customers receiving the notice, even those who have arranged preferred carrier freezes through their local service providers on the service(s) involved in the transfer, will be transferred to the acquiring carrier unless they have selected a different carrier before the transfer date; existing preferred carrier freezes on the service(s) involved in the transfer will be lifted; and the customers must contact their local service providers to arrange a new freeze;

6. Whether the acquiring carrier will be responsible for handling any complaints filed, or otherwise raised, prior to or during the transfer against the selling or transferring carrier; and

7. The toll-free customer service telephone number of the acquiring carrier.

22.23(3) *Carrier registration.*

a. Registration required. Each carrier that provides or bills for telecommunications services to customers located in Iowa shall register with the board and shall provide, at a minimum, the information specified in the form that appears in this subrule.

DEPARTMENT OF COMMERCE

UTILITIES BOARD

TELECOMMUNICATIONS SERVICE PROVIDER REGISTRATION

1. FULL NAME OF CARRIER PROVIDING SERVICE IN IOWA:

_____

2. CARRIER MAILING ADDRESS (including 9-digit ZIP code):

_____

_____

_____

3. NAME, TITLE, TELEPHONE NUMBER, E-MAIL ADDRESS, AND FAX NUMBER OF CONTACT PERSON:

_____

_____

_____

_____

4. ALL TRADE NAMES OR D/B/A'S USED BY CARRIER IN IOWA OR IN ADVERTISING OR BILLING THAT MAY REACH IOWA CUSTOMERS:

_____

_____

5. NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF AGENT IN IOWA AUTHORIZED TO ACCEPT SERVICE OF PROCESS ON BEHALF OF CARRIER:

_____

_____

_____

6. TYPES OF TELECOMMUNICATIONS SERVICE PROVIDED (CHECK ALL THAT APPLY):
____ LOCAL EXCHANGE SERVICE
____ INTEREXCHANGE SERVICE
____ DATA TRANSMISSION
____ ALTERNATIVE OPERATOR SERVICES ONLY
____ OTHER—PLEASE SPECIFY:_____
7. ATTESTATION. I, _____, certify that I am the company officer responsible for this registration, that I have examined the foregoing registration, and that to the best of my knowledge, information, and belief the information is accurate and will be updated as required.
Dated ____/____/____
SIGNATURE_____

b. Failure to register. Failure to file and reasonably update a registration, or provision of false, misleading, or incomplete information, may result in civil penalties under 22.23(5) and may be considered as evidence of a pattern or practice of violation of these rules.

22.23(4) *Subscriber complaints regarding changes in service—procedures.* When a telecommunications service provider is contacted by an Iowa customer alleging an unauthorized change in service, the service provider shall inform the customer of the customer's right to contact the board regarding the complaint. The service provider shall provide the customer with the board's toll-free number for complaints, (877)565-4450.

When a subscriber submits to the board a written complaint alleging an unauthorized change in service, the complaint will be processed by the board pursuant to 199—Chapter 6, "Complaint Procedures."

22.23(5) *Civil penalties and assessment of damages.*

a. Civil penalties. In addition to any applicable civil penalty set out in Iowa Code section 476.51, a service provider who violates a provision of the anti-slamming statute, a rule adopted pursuant to the anti-slamming statute, or an order lawfully issued by the board pursuant to the anti-slamming statute is subject to a civil penalty, which, after notice and opportunity for hearing, may be levied by the board, of not more than $10,000 per violation. Each violation is a separate offense.

b. Amount. A civil penalty may be compromised by the board. In determining the amount of the penalty, or the amount agreed upon in a compromise, the board may consider the size of the service provider, the gravity of the violation, any history of prior violations by the service provider, remedial actions taken by the service provider, the nature of the conduct of the service provider, and any other relevant factors.

c. Collection. A civil penalty collected pursuant to this subrule shall be forwarded by the executive secretary of the board to the treasurer of state to be credited to the general fund of the state and to be used only for consumer education programs administered by the board.

d. Exclusion from regulated rates. A penalty paid by a rate-of-return regulated utility pursuant to this subrule shall be excluded from the utility's costs when determining the utility's revenue requirement and shall not be included either directly or indirectly in the utility's rates or charges to its customers.

e. Civil actions. The board shall not commence an administrative proceeding to impose a civil penalty under this rule for acts subject to a civil enforcement action pending in court under Iowa Code section 714D.7.

f. Assessment of damages among interested persons. As a part of formal complaint proceedings, the board may determine the potential liability, including assessment of damages, for unauthorized changes in service among the customer, the previous service provider, the executing service provider, the submitting service provider, and any other interested persons. In the event of a soft slam, the board may impose joint and several liability on the reseller and the facilities-based service provider. For purposes of this rule and in the absence of unusual circumstances, the term "damages" means charges directly relating to the telecommunications services provided to the customer that have appeared or may appear on the customer's bill. The term "damages" does not include incidental, consequential, or punitive damages.

22.23(6) *Penalties for patterns of violations.* If the board determines, after notice and opportunity for hearing, that a service provider has shown a pattern of violations of these rules, the board may by order do any of the following:

a. Prohibit any other service provider from billing charges to residents of Iowa on behalf of the service provider determined to have engaged in such a pattern of violations.

b. Prohibit certificated local exchange service providers from providing exchange access services to the service provider.

c. Limit the billing or access services prohibition under paragraph *"a"* or *"b"* above to a period of time. Such prohibition may be withdrawn upon a showing of good cause.

d. Revoke the certificate of public convenience and necessity of a local exchange service provider.

22.23(7) *Service provider complaints regarding changes in service.* When a service provider files a written complaint charging another service provider with causing unauthorized changes in end user services to the detriment of the complaining service provider, the complaint will be processed pursuant to 199—Chapter 6, "Complaint Procedures," except that any party to the proceeding may petition the board for an order initiating formal complaint proceedings at any time, regardless of the status of the informal complaint proceedings. The board will grant such petitions or enter such an order on its own motion if the board finds that informal complaint proceedings are unlikely to aid in the resolution of the complaint.

199—22.24(476) Applications for numbering resources.

22.24(1) *Application to be filed with the board.* Any communications service provider, including but not limited to local exchange carriers, wireless service providers, and paging companies, applying for numbering resources with the North American Numbering Plan Administrator (NANPA) or the Pooling Administrator (PA) shall send a draft application or executed application to the board by facsimile transfer or electronic mail at least two days prior to the date on which the original application is to be received by the NANPA or PA. A draft application shall contain substantially the same information that is to be contained in an executed application. The application may be faxed to (515)281-5329 or electronically mailed to iubrecordscenter@iub.state.ia.us. Electronic submissions shall include "NANPA Application" or "PA Application" in the subject line.

22.24(2) *Confidential treatment.* The information contained in the draft applications or executed applications for numbering resources shall be held as confidential for a period of 90 days or until the new codes are entered into the local exchange routing guide (LERG), whichever is later.

22.24(3) *Content.* Each application filed with the board under this rule shall include a reference to this rule and sufficient information to identify the service provider and a contact person.

These rules are intended to implement Iowa Code sections 476.1 to 476.3, 476.5, 476.6, 476.8, 476.9, 476.29, 476.91, and 546.7 and Iowa Code Supplement section 476.103.

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◊ Two or more ARCs

1 Effective date of 12/1/83 of subrules 22.1(3), 22.2(5)*"v,"* and 22.3(13) delayed 70 days by the Administrative Rules Review Committee on 11/8/83.

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3 Effective date of 22.4(2)*"b"* delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 48
HISTORIC PRESERVATION AND CULTURAL AND ENTERTAINMENT DISTRICT TAX CREDITS

223—48.1(303,404A) Purpose. A historic preservation and cultural and entertainment district tax credit (hereafter referred to as historic tax credit) for rehabilitation of eligible commercial property, residential property and barns located in this state is granted to approved projects, subject to availability of the credit, to apply against the income tax imposed under Iowa Code chapter 422, division II, III, or V, or Iowa Code chapter 432. Historic tax credits are restricted to rehabilitation projects for eligible properties in Iowa. Rehabilitation projects for eligible properties must be conducted in accordance with the federal Standards for Rehabilitation (36 CFR Part 67.7) as described in the U.S. Secretary of the Interior's Standards for the Treatment of Historic Properties (hereafter referred to as Standards).

223—48.2(303,404A) Definitions. The definitions listed in Iowa Code section 17A.2 and rules 223—1.2(17A,303), 223—1.6(303), 223—13.2(303), 223—22.2(303), and 223—35.2(303) shall apply to terms as they are used throughout this chapter. In addition, the following definitions apply:

"Applicant" means the person, partnership, corporation, qualifying nonprofit organization, or public agency applying for the tax credit. In most cases, this will be the entity holding a fee-simple interest in the property or any other person or entity recognized by the Internal Revenue Code for purposes of the applicable tax benefits. If an application is made by someone other than the fee-simple owner, the application must be accompanied by a written statement signed by the fee-simple owner indicating the fee-simple owner does not object to the applicant claiming the tax credit.

"Assessed value" means the amount of the most current property tax assessment.

"Barn" means an agricultural building or structure, in whatever shape or design, which is used for the storage of farm products or feed or for the housing of farm animals, poultry, or farm equipment.

"Commercial property" means a building used for retail, office, or other uses not otherwise defined in this rule.

"Disaster recovery project" means an eligible property located in an area declared a disaster area by the governor of Iowa or by the president of the United States. The property must have been physically impacted as a result of the disaster.

"Employment base" means the number of jobs that exist at an eligible property on the date part one of the application is approved.

"Historic tax credit(s)" means the historic preservation and cultural and entertainment district tax credit established in Iowa Code chapter 404A.

"Mixed-use property" means an eligible property that includes three or more residential units and may also contain a commercial property component in the same building.

"New permanent jobs" means the number of new jobs that exist at an eligible property two years after the tax credit certificate is issued. New permanent jobs are calculated as those over and above the employment base.

"Placed in service" means the date on which a building receives a certificate of occupancy from the applicable city or county official or the date on which the building is placed in a condition or state of readiness and availability for a specifically assigned function, whether in a trade or business, in the production of income, in a tax-exempt activity, or in a personal activity.

"Qualified rehabilitation costs" means qualified rehabilitation expenditures under the federal rehabilitation credit in Section 47 of the Internal Revenue Code.

"Qualifying nonprofit organization" means an organization, other than governmental bodies, described in Section 501 of the Internal Revenue Code unless the exemption is denied under Section 501, 502, 503 or 504 of the Internal Revenue Code.

"Reserved tax credit" means the amount of tax credits set aside from the available tax credit fund for an approved project.

"Residential property" means a building with two or fewer residential units, with each unit providing complete, independent living facilities for one or more persons, including permanent provisions for living, sleeping, eating, cooking, and sanitation.

"Standards" means the Standards for Rehabilitation as described in the U.S. Secretary of the Interior's Standards for the Treatment of Historic Properties.

"Tax basis" means the same as defined in department of revenue 701—subrule 42.15(3).

"Tax credit year" means the tax year in which a tax credit certificate holder is eligible to redeem a tax credit certificate based on the availability of tax credits for an eligible project.

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223—48.3(303,404A) Eligible properties. The following properties are eligible for the historic tax credit:

1. Property verified as listed on the National Register of Historic Places or determined eligible for such listing through the established procedures of the state historic preservation office (SHPO);
2. Property designated as a building contributing to the historic significance of a district listed on the National Register of Historic Places or contributing to the historic significance of a district determined eligible for such listing through the established procedures of the SHPO;
3. A property or district designated as a local landmark by a city or county ordinance; or
4. A barn constructed prior to 1937.

223—48.4(303,404A) Qualified and nonqualified rehabilitation costs.

48.4(1) Qualified rehabilitation costs are as defined in Section 47, rehabilitation credit, of the Internal Revenue Code.

48.4(2) Costs deducted as expenses in the tax year in which they are paid or incurred are nonqualified rehabilitation costs for determination of historic tax credits.

48.4(3) Architectural and engineering fees, site survey fees, legal fees, insurance premiums, development fees and other construction-related expenses are qualified rehabilitation costs for determination of historic tax credits to the extent they increase the tax basis of the eligible property.

48.4(4) Sidewalk, parking lot and landscaping expenses are nonqualified rehabilitation costs for determination of historic tax credits.

48.4(5) Only qualified rehabilitation costs incurred during the 24-month period immediately prior to the date the building was placed in service may be used for determination of historic tax credits, excluding any costs incurred prior to inception of this program.

a. Qualified rehabilitation costs incurred prior to approval by the SHPO of part two of the application (see rule 223—48.6(303,404A)) may be considered in the determination of historic tax credits.

b. Applicants who undertake rehabilitation projects without prior approval from the SHPO do so at their own risk.

48.4(6) Any submission of a part three of the application with qualified rehabilitation costs of more than $500,000 shall include a certified statement by a certified public accountant verifying that the expenses statement includes only qualified rehabilitation costs incurred in the time period established in subrule 48.4(5).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.5(303,404A) Rehabilitation cost limits and amount of credit.

48.5(1) For commercial or mixed-use property, the amount of rehabilitation costs must equal at least 50 percent of the assessed value of the property, excluding the land, prior to rehabilitation.

48.5(2) For residential property or for barns, the amount of rehabilitation costs must equal at least $25,000 or 25 percent of the assessed value of the property, excluding the land, prior to rehabilitation, whichever is less.

48.5(3) For residential or mixed-use property, the amount of rehabilitation costs shall not exceed $100,000 per residential unit excluding any qualified rehabilitation costs for the public or commercial

space and excluding any qualified rehabilitation costs for the weather surfaces of the building envelope including exterior windows and doors.

48.5(4) The historic tax credit for a project shall equal 25 percent of the qualified rehabilitation costs.

48.5(5) Applicants may develop subsequent projects for qualified rehabilitation costs not previously included in a tax credit application for a building which had tax credits previously reserved or awarded. Each subsequent application shall meet eligibility requirements as stated in subrules 48.5(1) to 48.5(4) and shall be reviewed individually and independently.

a. Applicants who select to phase their work under the federal historic tax credit program may submit individual state applications for each phase of the federal project. Phased federal projects shall not apply for the small projects fund.

b. For applicants receiving credits through the small projects fund, the cumulative total for multiple applications for a single building shall not exceed $500,000 in qualified rehabilitation costs. The SHPO will not accept an application for a building previously receiving credits through the small projects fund that causes the cumulative total to exceed $500,000. The applicant may either:

(1) Apply for the cumulative total of qualified rehabilitation costs under any other fund for which the project is eligible. If the applicant receives a tax credit reservation from another fund, the applicant shall abandon the entirety of the applicant's tax credit reservation in the small projects fund in accordance with rule 223—48.12(303,404A); or

(2) Apply for only the qualified rehabilitation costs up to a cumulative total of $500,000. If the applicant has already received and claimed a tax credit certificate on the applicant's annual tax return, the applicant shall select this option.

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223—48.6(303,404A) Application and review process.

48.6(1) All applications for historic tax credits shall be on the current state fiscal year's forms and in accordance with the current state fiscal year's instructions provided by the SHPO. All applications must be complete and include all required supporting documentation before being considered for review and before beginning the review periods outlined in subrule 48.6(3). Application forms are available from the Tax Incentives Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319-0290. Applications may also be downloaded from the department of cultural affairs—state historical society of Iowa Web site.

a. Part one of the application identifies the eligibility of the property for the historic tax credit. Part one of the application is accepted year-round. Part one of the application must include all requested information. SHPO staff shall notify the applicant if part one of the application is incomplete. Incomplete applications will not be processed.

b. Part two of the application provides a detailed description of the rehabilitation project. Part two of the application is accepted when tax credits are available for the fund specified by the applicant pursuant to subrule 48.7(6) or, if no tax credits are available, in accordance with rule 223—48.8(303,404A). Part two of the application must include all requested information. SHPO staff shall notify the applicant if part two of the application is incomplete. Incomplete applications will not be processed.

c. Part three of the application provides the information and documentation required to request certification of project completion and includes an economic impact questionnaire. Part three of the application shall be submitted within six months of the date on which the building is placed in service or, if the project is complete, part three of the application may be submitted simultaneously with part two of the application. Part three of the application must include all requested information including certification in accordance with subrule 48.4(6). SHPO staff shall notify the applicant if part three of the application is incomplete. Incomplete applications will not be processed. Incomplete applications may be subject to abandonment as outlined in rule 223—48.12(303,404A).

d. Amendments to applications. An applicant shall amend an approved part one of the application or an approved part two of the application if the property changes ownership or if the applicant’s name or address changes. An applicant may amend an approved part two of the application to notify SHPO of, and to request review of, modifications to the original description of the rehabilitation project. Amendments

to part two of the application shall not include modification of the rehabilitation costs estimated in the originally approved part two of the application. Amendments to part two of the application shall not result in the reservation of additional tax credits for a project.

e. An application will not be accepted for a building placed in service more than five years before part two of the application is submitted.

48.6(2) SHPO staff trained by the National Park Service for reviewing rehabilitation projects to ensure compliance with Standards will review part two and part three of each submitted application.

48.6(3) SHPO staff shall review and respond to each part of a completed or amended application within 90 days of receipt when submitted pursuant to subrule 48.6(1). If an applicant submits more than one part of the application simultaneously, SHPO staff shall review each part sequentially and the 90-day review period for part two or three of the application will begin upon approval of the previous part.

48.6(4) A part two of an application that includes the same scope of work as a rehabilitation project which qualifies for the federal rehabilitation credit under Section 47 of the Internal Revenue Code shall automatically be approved when reviewed in accordance with subrule 48.6(7) and to the extent that all historic tax credits appropriated for the fiscal year have not already been reserved.

48.6(5) Response to application parts.

a. Review of part one of the application shall result in one of two responses:

(1) The property is eligible for the historic tax credit; or

(2) The property is not eligible for the historic tax credit.

b. Review of part two of the application shall result in one of three responses which may be provided to the department of revenue:

(1) The rehabilitation described in the application is consistent with the historic character of the property or the district in which it is located, and the project meets the Standards. The initial review of part two is a preliminary determination only. A formal certification of rehabilitation shall be issued only after rehabilitation work is completed;

(2) The rehabilitation or proposed rehabilitation described in part two of the application will meet the Standards if the stipulated conditions are met; or

(3) The rehabilitation described in part two of the application is not consistent with the historic character of the property or the district in which it is located, and the project does not meet the Standards. The application will not be approved and SHPO will not reserve tax credits for the project.

c. Review of part three of the application shall result in one of two responses which may be provided to the department of revenue:

(1) The completed rehabilitation meets the Standards and is consistent with the historic character of the property or the district in which it is located. Effective on the date of approval of part three of the application, the project shall be designated a "certified rehabilitation"; or

(2) The rehabilitation is not consistent with the historic character of the property or the district in which it is located, and the project does not meet the Standards. If the work cannot be corrected to meet the Standards, the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

d. Questions concerning specific tax consequences or interpretation of the state tax code must be addressed to the department of revenue.

48.6(6) Approval of part one of the application. Upon approval of part one of the application, an applicant may proceed to submission of part two of the application. If the applicant submitted part two of the application simultaneously, the SHPO shall complete review of part one of the application before reviewing part two of the application.

48.6(7) Approval of part two of the application.

a. Upon approval of part two of the application with no conditions, the SHPO shall reserve tax credits for the project in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the earliest year in which tax credits are available in the appropriate fund, and the applicant may proceed to implement the project.

b. Upon approval of part two of the application with conditions, the SHPO shall reserve tax credits for the project in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the

earliest year in which tax credits are available in the appropriate fund. The applicant may proceed to implement the project, and the applicant shall document compliance with the conditions.

c. An authorized representative of the SHPO, with due notice to the applicant, may inspect projects to determine if the work meets the Standards.

48.6(8) Approval of part three of the application. Upon approval of part three of the application, the SHPO shall issue a tax credit certificate to the applicant in an amount equal to 25 percent of the qualified rehabilitation costs as estimated in part two of the application for the tax credit year originally reserved for the project upon approval of part two of the application, unless the qualified rehabilitation costs in part three of the application differ from the estimated qualified rehabilitation costs in part two of the application.

a. If the qualified rehabilitation costs documented in part three of the application are less than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue a certificate in an amount equal to 25 percent of the final qualified rehabilitation costs and return any unused tax credits to the tax credit fund from which they were reserved.

b. For projects with tax credits reserved from the small projects fund and final qualified rehabilitation costs of $500,000 or less: If the final qualified rehabilitation costs documented in part three of the application are greater than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue tax credit certificates totaling 25 percent of the final qualified rehabilitation costs, with the initial tax credit certificate issued in the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the small projects fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

c. For projects with tax credits reserved from the small projects fund and final qualified rehabilitation costs over $500,000: The SHPO shall notify the applicant that the applicant may either:

(1) Apply for the cumulative total of qualified rehabilitation costs under any other fund for which the project is eligible. If the applicant receives a tax credit reservation from another fund, the applicant shall abandon the entirety of the applicant's tax credit reservation in the small projects fund in accordance with rule 223—48.12(303,404A); or

(2) Claim only the final qualified rehabilitation costs up to $500,000. If the applicant chooses this option, the SHPO shall issue tax credit certificates totaling no more than $125,000 for the project, with the initial tax credit certificate issued in the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the small projects fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

d. For projects with tax credits reserved from any other fund: If the final qualified rehabilitation costs documented in part three of the application are greater than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue tax credit certificates totaling 25 percent of the final qualified rehabilitation costs in the same fund from which tax credits were initially awarded, with the initial tax credit certificate issued for the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the appropriate fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

48.6(9) Disaster recovery projects. An applicant may apply for the disaster recovery fund as described in subrule 48.7(3) if the project meets the following requirements:

a. The initial submittal of part two of the application shall be made no later than the first filing window (see subrule 48.8(2)) that occurs after the five-year anniversary of the disaster declaration date. This time period may be waived in accordance with Iowa Code section 17A.9A. Petitions for waivers shall be directed to the Director, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319.

b. Disasters declared before January 1, 2008, will not be considered.

48.6(10) Projects creating new permanent jobs. An applicant may apply for the new permanent jobs fund as described in subrule 48.7(4) if the applicant meets the following requirements:

a. The applicant shall document the employment base for an eligible property on the date part one of the application is approved;

b. The applicant must provide information to SHPO documenting the creation of at least 500 new permanent jobs within two years of the date on which part three of the application is approved. This information shall be verified by the Iowa department of economic development using the process outlined in 261—Chapter 188, Iowa Administrative Code. If the Iowa department of economic development is unable to verify the number of new permanent jobs required, tax credits claimed by the applicant will be subject to repayment to the department of revenue and unclaimed credits shall be unavailable; and

c. The applicant (and any leaseholders or tenants, if applicable) must enter into a contract with the SHPO specifying the employment base, reporting mechanisms required to document 500 new permanent jobs, applicable dates for reporting, and the penalty incurred if reporting requirements are not met. If the contract is not executed before the building is placed in service, the SHPO shall recapture any tax credits reserved in accordance with rule 223—48.12(303,404A).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.7(303,404A) Tax credit funds.

48.7(1) *The small projects fund.* The SHPO shall reserve 10 percent of the tax credit allocation for any tax credit year in a small projects fund for projects with final qualified rehabilitation costs totaling $500,000 or less.

a. At the end of each state fiscal year, any credits in the small projects fund that have not been reserved for small projects shall be available for small projects in subsequent fiscal years.

b. If the small projects fund is fully reserved, any applications for small projects received after full reservation of the small projects fund may be eligible for the statewide fund.

48.7(2) *The cultural and entertainment district and great places fund.* The SHPO shall reserve 30 percent of the tax credit allocation for any tax credit year in a cultural and entertainment district and great places project (CED-GP) fund for projects located in cultural and entertainment districts certified in accordance with Iowa Code section 303.3B or for projects identified in Iowa great places agreements developed in accordance with Iowa Code section 303.3C.

48.7(3) *The disaster recovery fund.* The SHPO shall reserve 20 percent of the tax credit allocation for any tax credit year in a disaster recovery fund for projects located in an area declared a disaster area by the governor of Iowa or by the president of the United States. The eligible property must have been physically impacted as a result of the natural disaster as documented in accordance with the current state fiscal year's forms and instructions. The initial application for the project must be submitted within the time frame provided by subrule 48.6(9).

48.7(4) *The new permanent jobs fund.* The SHPO shall reserve 20 percent of the tax credit allocation for any tax credit year in a new permanent jobs fund for projects that involve the creation of more than 500 new permanent jobs within two years of the date on which part three of the application is approved.

48.7(5) *The statewide fund.* The SHPO shall reserve the remaining percentage of the tax credit allocation for any tax year in a statewide fund, which is to be used for eligible projects throughout the state of Iowa. If the statewide fund is fully reserved before the end of the state fiscal year, subsequent applications will be accepted utilizing the procedures in rule 223—48.8(303,404A).

48.7(6) *Fund selection.* Part two of the application shall clearly indicate the fund for which the applicant is applying. Only one fund may be selected. Any applications not indicating a specific fund shall be considered for the statewide fund. If an application is not eligible for the fund selected, it shall be considered for the statewide fund.

48.7(7) *Disposition of unreserved credits.* In reference to the new permanent jobs fund, CED-GP fund, and disaster recovery fund, at the end of the filing window in any fiscal year, any tax credits that have not been reserved will be reallocated in the same fiscal year as follows:

a. Unreserved CED-GP fund and new permanent jobs fund credits will be reallocated to the disaster recovery fund.

b. Unreserved disaster recovery fund credits will be reallocated to the statewide fund.

c. For purposes of this subrule, the phrase "in any fiscal year" refers to each of the three fiscal years for which credits may be reserved pursuant to Iowa Code section 404A.4(5) as amended by 2009 Iowa Acts, Senate File 481, section 3.
[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.8(303,404A) Sequencing of applications for review.

48.8(1) *Order of review.* The SHPO anticipates the receipt of a large number of applications for historic tax credits for projects with qualified rehabilitation costs in excess of $500,000 at the beginning of each state fiscal year. At the start of each state fiscal year, the SHPO will utilize a project review sequencing and prioritization system to establish the order in which applications will be reviewed.

a. Applications for projects with qualified rehabilitation costs of $500,000 or less applying for credits from the small projects fund will be accepted and reviewed throughout the calendar year until all available credits from that fund are reserved. When all available credits are reserved from the small projects fund, subsequent applications will be accepted utilizing the procedures in subrules 48.8(2) to 48.8(7).

b. If all available credits are reserved before review of all projects submitted within the filing window specified in subrule 48.8(2), applications not reviewed will be returned to the applicant.

48.8(2) *Filing window.* Part two applications for state historic tax credits received during the first ten working days of the state fiscal year shall be included in a project review sequencing system to determine the order in which they will be reviewed. The filing window for applications submitted in July 2009 will be extended to August 7, 2009.

48.8(3) *Initial sequencing process.* An initial sorting process based on the status of the project application at the start of the state fiscal year will be used to associate applications with the appropriate initial sequencing category. Following initial sorting into a category and subcategory, each application within the assigned category and subcategory will be sequenced in accordance with subrule 48.8(4).

a. Category A projects do not need to be resubmitted during the filing window and are comprised of two subcategories in the following order:

(1) Projects reviewed in the previous year's sequencing and review process that did not receive a reservation for the full 25 percent of their qualified rehabilitation costs.

(2) Projects with final qualified rehabilitation costs documented in part three of the application in excess of the estimated rehabilitation costs in part two pursuant to paragraph 48.6(8)*"b"* and which could not be otherwise reserved from available credits in the appropriate fund.

b. Category B projects are comprised of projects for which part two of a state historic tax credit application was submitted during any previous year's filing window, as verified by records maintained at the SHPO, and was included in that year's sequencing system, and did not receive a tax credit reservation. Category B projects must be resubmitted during the current year's filing window and must specify a fund pursuant to subrule 48.7(6). Category B projects will be divided into subcategories arranged in the following order:

(1) Projects will be included in a subcategory for the state fiscal year of original submission provided the project was included in each successive state fiscal year's sequencing system and did not receive a tax credit reservation. These subcategories will be arranged chronologically beginning with the earliest state fiscal year.

(2) Any projects for which applications were not submitted in successive state fiscal years will be included in a subcategory after those defined in subparagraph 48.8(3)*"b"*(1).

c. Category C projects are comprised of an entirely new part two of a state historic tax credit application not meeting the requirements for any other category and having been received within the specified filing window. Projects may consist of parts one and two of the application, parts two and three of the application with a part one having already been submitted, or parts one, two and three of the application. Category C projects must be submitted during the current year's filing window and must specify a fund pursuant to subrule 48.7(6).

48.8(4) *Secondary sequencing process.* Using a random number generator, SHPO staff will assign unique, random numbers to all applications that are eligible for inclusion in the review sequencing

system within each category and subcategory of the initial sequencing system. Applications within each category and subcategory shall then be placed in numeric order from lowest to highest. SHPO staff shall then create a master sequence list, with category A applications, arranged by subcategory, sequenced first; category B applications, arranged by subcategory, sequenced next; and category C applications sequenced last.

48.8(5) *Random number generator.* SHPO staff shall use a random number generator utility found in Microsoft Excel 2003 or the current version of Microsoft Excel generally used by the department of cultural affairs.

48.8(6) *Outside observer.* The initial sequencing process, the secondary sequencing process, and the development of the master sequence list will be observed and certified by an official state witness.

48.8(7) *Prioritization of review according to fund.* Once the master sequence list is set, the projects will be reviewed by fund in the sequential order in which they fall on the list.

a. Category A projects will be reviewed and reserved first. SHPO shall reserve the remaining credits for the project from the same tax credit fund selected by the applicant pursuant to subrule 48.7(6) if a selection was made. Otherwise, SHPO shall reserve the remaining credits for the project from the same tax credit fund from which the original reservation came or from another fund for which the project is eligible.

b. Following review of category A projects, tax credit funds will be reviewed in the following order:

(1) Small projects fund, CED-GP fund, and new permanent jobs fund.

(2) Disaster recovery fund.

(3) Statewide fund.

c. Any tax credits that have not been reserved in a particular fund will be transferred, if applicable, to the appropriate fund as outlined in rule 223—48.7(303,404A). If a fund is exhausted before the completion of reviews for that fund, all remaining projects in that fund shall be eligible for the statewide fund and will be considered in the order shown on the master sequence list.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.9(303,404A) Reserved tax credits.

48.9(1) Upon written approval of part two of the project application, the SHPO shall reserve an estimated tax credit under the name of the applicant(s) in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the earliest year in which tax credits are available.

48.9(2) If the amount of estimated qualified rehabilitation costs changes during the course of project implementation, the applicant may include those costs in part three of the application.

48.9(3) The SHPO shall not reserve tax credits for more than two state fiscal years beyond the current state fiscal year.

48.9(4) Of the amount of tax credits that may be reserved in state fiscal years 2010, 2011, and 2012:

a. For state fiscal year 2010, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2009. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2010.

b. For state fiscal year 2011, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2010. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2011.

c. For state fiscal year 2012, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2011. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2012.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.10(303,404A) Project commencement.

48.10(1) Once a tax credit reservation is made for a project, rehabilitation must begin before the end of the state fiscal year in which the SHPO approved part two of the application. The applicant shall submit to the SHPO a project commencement report and cover letter certifying the commencement date of rehabilitation and outlining expenditure of qualified rehabilitation costs. This report and cover letter are due within the first ten working days of the next state fiscal year. Information about the project commencement report is available from the Tax Incentives Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319-0290. It may also be downloaded from the department of cultural affairs—state historical society of Iowa Web site.

48.10(2) In the event rehabilitation on a project does not begin before the end of the state fiscal year in which the SHPO approved part two of the application, the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09; **ARC 8873B**, IAB 6/30/10, effective 6/10/10]

223—48.11(303,404A) Project completion.

48.11(1) Once a tax credit reservation is made for a project, construction must be completed and the building must be placed in service within 36 months of the date on which part two of the application is approved. For projects with tax credits reserved prior to July 1, 2009, construction must be completed and the building must be placed in service on or before June 30, 2011. The applicant must submit part three of the application within six months of the date on which the building is placed in service regardless of the 36-month deadline, unless part three of the application is submitted simultaneously with part two.

48.11(2) In the event actual construction on a project is not completed and the building is not placed in service within the time period allowed in accordance with subrule 48.11(1), the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.12(303,404A) Abandonment and recapture of tax credit reservation.

48.12(1) *Project abandonment due to inability to meet commencement deadline.* If the applicant has not provided the SHPO documentation of project commencement in accordance with rule 223—48.10(303,404A), the SHPO shall, by registered U.S. mail or courier sent to the last-known address of the applicant, request that the appropriate documentation be filed within 30 days of the date of the letter. If the SHPO has not received the documentation by the 30-day deadline, then the SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. If either letter is returned as undeliverable, the letter shall be filed and the tax credit reservation processed in accordance with subrule 48.12(5). Application processing fees for part two of the application as allowed by rule 223—48.16(303,404A) will not be returned.

48.12(2) *Project abandonment due to inability to meet project completion deadline.* If the applicant has not provided the SHPO documentation of project completion in accordance with rule 223—48.11(303,404A), the SHPO shall, by registered U.S. mail or courier sent to the last-known address of the applicant, request that part three of the application be filed within 30 days of the date of the letter. If the SHPO has not received part three of the application by the 30-day deadline, then the SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. If either letter is returned as undeliverable, the letter shall be filed and the tax credit reservation processed in accordance with subrule 48.12(5). Application processing fees for part two of the application as allowed by rule 223—48.16(303,404A) will not be returned.

48.12(3) *Project abandonment at the request of an applicant.* An applicant may choose to abandon tax credits reserved in accordance with subrule 48.6(7) at any time after the date on which the tax credit was reserved. A tax credit reservation may be voluntarily abandoned for any reason, including abandonment of a reservation from the small projects fund for consideration in another fund in accordance with paragraph 48.5(5)*"b"* or paragraph 48.6(8)*"c."* Submittal of a new application will require the submittal of a new processing fee. Processing fees for the original part two application(s)

as allowed by rule 223—48.16(303,404A) will not be returned. To abandon a tax credit reservation, the applicant shall send a letter to the SHPO requesting that the tax credit project be abandoned. The SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. SHPO shall process the tax credit reservation in accordance with subrule 48.12(5).

48.12(4) *Tax credit recapture if part three of the application is not approved.* If as part of the SHPO review of part three of the application pursuant to subrule 48.6(5) rehabilitation work is found to be inconsistent with the historic character of the property or the district in which it is located and the applicant is unwilling or unable to correct the work accordingly, the SHPO shall notify the applicant by registered U.S. mail or courier that the tax credit reservation has been recaptured and shall process the tax credit reservation in accordance with subrule 48.12(5).

48.12(5) *Tax credit return to appropriate fund.* The SHPO shall return any recaptured tax credit reservations to the tax credit fund from which they were reserved.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.13(303,404A) Transfer of tax credit certificate. The applicant may transfer the tax credit certificate to one or more parties in accordance with department of revenue 701—subrule 42.15(6).

223—48.14(303,404A) Redemption of tax credit certificate. The tax credit holder shall attach the tax credit certificate and a copy of the signed part three of the application to the taxpayer's state income tax return and submit these documents to the department of revenue in the tax year for which the tax credit certificate is valid.

223—48.15(303,404A) Tax credits in excess of tax liability.

48.15(1) An applicant whose tax credit exceeds the tax liability in the tax year for which the tax credit may be redeemed is entitled to a refund of the excess tax credit with interest under Iowa Code section 422.25. See also administrative rules of the department of revenue, particularly rules 701—42.15(422) and 701—52.18(422).

48.15(2) In lieu of a refund, the applicant may have the excess tax credit applied to the tax liability for the following year.

223—48.16(303,404A) Application processing fees. A nonrefundable fee for application processing of parts two and three of an application will be charged for review of requests for certification of a rehabilitation project for historic tax credits. An initial review fee will be due with the filing of part two of an application. An additional fee for review of completed rehabilitation work will be due with the filing of part three of an application. Fees will be based on the amount of qualified rehabilitation costs. The fee schedule is as follows:

For projects with qualified rehabilitation costs of:	Part 2 Processing Fee	Part 3 Processing Fee
$50,000 or less	No cost	No cost
$50,001 to $100,000	$250	$250
$100,001 to $500,000	$500	$500
$500,001 to $1,000,000	$750	0.5 percent of qualified rehabilitation costs (i.e., 0.005 × costs)
$1,000,001 to $6,000,000	$1,000	
Over $6,000,000	$1,500	$30,000

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.17(303,404A) Appeals.

48.17(1) Applicants may appeal a decision of the SHPO on any of the following bases:

a. Action was outside statutory authority;

b. Decision was influenced by a conflict of interest;

c. Action violated state law or administrative rules;

d. Insufficient public notice was given; or

e. Alteration of the review and certification process was detrimental to the applicant.

48.17(2) Appeals in writing shall be delivered to the director of the department of cultural affairs within 30 days of the decision giving rise to the appeal. All appeals shall be directed to the Director, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319; telephone (515)281-7471.

48.17(3) All appeals shall contain:

a. The facts of the case;

b. Argument(s) in support of the appeal; and

c. The remedy sought.

48.17(4) The director of the department of cultural affairs shall consider and rule on an appeal after receiving all documentation from the appellant and shall notify the appellant in writing of the decision within 30 days. The decision of the director of the department of cultural affairs shall be final except as provided in Iowa Code sections 17A.19 and 17A.20.

48.17(5) Applicants may appeal SHPO decisions provided under subrule 48.6(5) regarding eligibility of a property to be placed on the National Register as determined during part one of the application and review process or regarding whether a proposed scope of work meets the Standards as determined during part two of the application and review process. The SHPO shall provide procedural guidance to the applicant should the applicant choose to appeal to the National Park Service under this subrule.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

These rules are intended to implement Iowa Code chapter 303 and chapter 404A as amended by 2009 Iowa Acts, Senate File 481.

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ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

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IOWA JOBS MAIN STREET PROGRAM

261—40.1(83GA,SF2389) Authority. The authority for establishing the Iowa jobs main street program is provided in 2010 Iowa Acts, Senate File 2389, sections 10 and 68.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.2(83GA,SF2389) Purpose. The purpose of the program is to fund projects that are currently on the department's highest-priority list. The highest-priority list shall include those projects that have previously applied for funding consideration or have received partial funding for façade master plans to rehabilitate storefronts in Iowa main street districts; that complete streetscape projects where planning and the majority of funding are already secure; that are unfunded main street challenge grant projects; and that are other building rehabilitation projects.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.3(83GA,SF2389) Definitions.

"Department" means the Iowa department of economic development.

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

"Eligible applicant" means a department-designated main street organization that participates in the Iowa main street program described by 261—Chapter 39 and that has a current contract with the department for participation in the program.

"Grant" means funds received through the program as evidenced by an agreement with the department.

"Grantee" means any eligible applicant receiving funds under the program.

"Highest-priority list" means the list of projects developed under these rules that contains a description and prioritization of main street projects eligible for funding under the program.

"Program" means the Iowa jobs main street program.

"Project" means a project that has previously applied to the department under its main street program, sustainable community fund, or downtown revitalization fund.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.4(83GA,SF2389) Highest-priority list. The director shall compile at least annually a highest-priority list of projects proposed for funding and shall publish the highest-priority list on the department's Web site.

40.4(1) *Eligibility.* To be eligible to be included on the highest-priority list, the proposed project must be managed or owned by an eligible applicant, be eligible for main street funding described in 261—Chapter 39, and meet one of the following requirements:

a. The project has previously applied for funding consideration or has received partial funding for façade master plans to rehabilitate storefronts in Iowa main street districts through the department's community development programs;

b. The project is a complete streetscape project for which planning and the majority of funding is already secure;

c. The project is an unfunded project through the main street challenge grant described in 261—Chapter 39; or

d. The project is a building rehabilitation project.

40.4(2) *Priority.* Proposed projects shall be prioritized based on the following criteria:

a. The eligible applicant is in good standing with the department, that is, the eligible applicant is conforming with contractual requirements or has satisfactorily performed under prior awards.

b. The project is currently under construction or has adequate development of construction documents so that it could be under construction within 60 days of award. For purposes of this subrule, "under construction" shall mean that construction contracts have been executed by the grantee or its subrecipients.

c. The project could be completed within the grant period of 18 months from the date of award.

d. The project has demonstrated a broad base of funding outside the public investment.

e. The project is utilizing, intends to utilize, or has utilized state or federal historic tax credits, as evidenced by appropriate filings to the state historic preservation office.

f. The project conforms to the state of Iowa's Green Streets Criteria, version 2.0, published in August 2009.

g. The project is considered a key structure or group of structures in a historic commercial district.

h. The project, if funded, would likely result in job creation or revenue increases for the community.

i. The estimated costs of the project are documented and credible.

40.4(3) *Additional information.* The department may request additional information from eligible applicants in developing the highest-priority list. Failure on the part of an eligible applicant to provide additional information to the department in the form and by the date requested may result in an eligible applicant's project not being included in the highest-priority list.

[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.5(83GA,SF2389) Funding. All Iowa jobs funds shall be awarded and used as specified in 2009 Iowa Acts, Senate File 376, and 2010 Iowa Acts, Senate File 2389, and these rules. Funds shall be paid on a reimbursement basis as described in the grant agreement. Any portion of an amount awarded for projects that remains unexpended upon completion of the project may be reallocated to other projects on the highest-priority list at the discretion of the director.

40.5(1) *Timing of grants.* The funding of projects on the highest-priority list under the program is contingent upon the availability of funds allocated to the department. When funds are available, the department shall fund main street projects on the highest-priority list in the order they are listed and subject to the conditions of these rules.

40.5(2) *Grant period.* A grantee may receive a grant for a term not to exceed 18 months unless otherwise agreed upon by the department and included as part of the grant agreement or amendment thereof.

40.5(3) *Compliance and termination.* Continued funding through the grant period is contingent upon acceptable audit and monitoring reports received by the department and the grantee's compliance with the terms and conditions of the grant agreement. The department may terminate or suspend funding, in whole or in part, if there is a substantial violation of a specific provision of the agreement or these rules and corrective action has not been taken by the grantee.

40.5(4) *Allowable cost.* Funds granted by this program to a grantee shall be applied toward the project described in the grant agreement.

40.5(5) *Ineligible costs.* In addition to any limitations described in the grant agreement, funds shall not be used for the following:

a. Expenditures made prior to the date of the award.

b. The refinancing of a loan existing prior to the date of the award.

c. Administrative costs of the grantee.

d. Routine, recurring maintenance or operational expenses of the project.

e. Purchase of real property.

40.5(6) *Amendments.* Any substantive change to a grant agreement shall be considered an amendment. Amendments must be requested in writing by the grantee and shall not be considered effective until the director has approved and executed such an amendment. All amendments must be executed in conformance with the grant agreement and these rules.

[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.6(83GA,SF2389) Financial management.

40.6(1) *Audits.* All grants under the program are subject to audit. Grantees shall be responsible for the procurement of audit services and for the payment of audit costs. Audits may be performed by the state auditor's office or by a qualified independent auditor. Representatives of the department and the state auditor's office shall have access to all books, accounts, documents and records belonging to, or in use by, grantees pertaining to the receipt of a grant under these rules.

40.6(2) *Record retention.* All records shall be retained for five years beyond the grant period or longer if any litigation or audit is begun or if a claim is instituted involving the grant or agreement covered by the record. In these instances, the records shall be retained until the litigation, audit or claim has been resolved.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.7(83GA,SF2389) Reports.

40.7(1) *General reporting requirements.* Reports shall include information required by the grant agreement and shall be submitted to the department at intervals described in the grant agreement. The reports shall assess the use of funds in accordance with the program's objectives and progress of the program activities.

40.7(2) *Job creation.* The grantee shall report the total number of jobs created as a result of the project along with other information related to the quality of such jobs, including hours and wages, as requested by the department. For purposes of this rule, the number of jobs created may be calculated by determining which new employment positions created and filled would not have been continued were it not for this program. This would include both permanent and temporary positions filled by the grantee, a contractor or a subcontractor, including construction contractors and their employees. This requirement shall be in effect for two years beyond the project's completion.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.8(83GA,SF2389) Signs. Each project shall recognize in a prominent location and manner the fact that the project was made possible, in part, through a grant from the Iowa jobs program. During the construction period, the recognition (including a display of the Iowa jobs logo) may be located on temporary signage. The completed project shall feature a permanent acknowledgment, such as a plaque or similar commemoration. Other benefactors of the project may be similarly acknowledged as well. The department may provide funding to the grantees for these signs using funds appropriated to the department through 2010 Iowa Acts, Senate File 2389, sections 10 and 68.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.9(83GA,SF2389) Noncompliance. If the department finds that a grantee is not in compliance with the requirements under this program, the grantee will be required to refund to the state all disallowed costs. Reasons for a finding of noncompliance include, but are not limited to, a finding that the grantee is using program funds for unauthorized activities, has failed to complete approved activities in a timely manner, has failed to comply with applicable laws and regulations or the grant agreement, or lacks the capacity to carry out the purposes of the program.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

261—40.10(83GA,SF2389) Great places consideration. In compliance with Iowa Code section 303.3C, projects that are identified in an Iowa great places agreement developed pursuant to section 303.3C that are otherwise eligible projects under these rules shall receive additional consideration for placement on the highest-priority list. Such additional consideration shall be afforded only to those projects that have been identified as an Iowa great place under Iowa Code section 303.3C within the past three years.
[**ARC 8922B**, IAB 6/30/10, effective 6/11/10]

These rules are intended to implement 2010 Iowa Acts, Senate File 2389, sections 10 and 68.

[Filed Emergency ARC 8922B, IAB 6/30/10, effective 6/11/10]

CHAPTER 80
IOWA SMALL BUSINESS LOAN PROGRAM

261—80.1(83GA,SF2389) Purpose. The purpose of the program is to promote the creation and retention of jobs in the state's economy and to assist businesses to be more competitive by aiding entrepreneurs and small businesses in their efforts to upgrade or modernize equipment; realize additional efficiencies in their supply chains; improve their distribution and transportation margins; reduce facility costs through increased energy efficiency; and leverage other sources of business financing.
[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.2(83GA,SF2389) Authority. The authority for establishing the program is provided in 2010 Iowa Acts, Senate File 2389, sections 41 through 44.
[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.3(83GA,SF2389) Definitions.

"Administrator" means the organization designated by the department pursuant to rule 261—80.4(83GA,SF2389) to administer portions of the program.

"Co-financed loan" means a loan made under this program to a recipient who has contingent approval from another lender for leverage of other sources of business financing for the recipient's Iowa small business at the time of origination.

"Department" means the Iowa department of economic development.

"Direct loan" means a loan made under this program that is not part of a co-financing arrangement with another lender.

"Director" means the director of the department.

"Iowa small business" means a business located in Iowa that is owned, operated and actively managed by an Iowa resident and that has 35 or fewer full-time equivalent employees.

"Program" means the Iowa small business loan program.

"Recipient" means an Iowa small business that has applied for and received a loan under the program.
[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.4(83GA,SF2389) Administrator. The department may enter into an agreement with and thereby designate a nonprofit organization to administer portions of the program provided the nonprofit organization is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and is designated by the United States Small Business Administration as a statewide microloan provider. Among other duties identified in the agreement, the administrator may manage the program application and review process to ensure consistency with these rules and may make recommendations to the department for loan approval under the program.
[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.5(83GA,SF2389) General loan terms. In addition to terms and conditions in the loan agreement, loans made under the program shall have the following terms:

80.5(1) *Amount.* Loans made under the program may be for $2,500 to $50,000.

80.5(2) *Interest rates.* The interest rates for the following loans made available under the program shall be:

a. Direct loans: annual percentage rate of 3.9 percent.

b. Co-financed loans: annual percentage rate of 2 percent.

80.5(3) *Security.* Recipients must provide collateral to secure the entire loan value. The department may require a first position on any collateral offered in connection with receiving a loan under the program or any equipment purchases or other uses that can be securitized. The department may, however, allow for a subordinated position on collateral on co-financed loans that involve a conventional lender.

80.5(4) *Term.* The term of any loan made under the program shall not exceed five years. The department may require a shorter loan term for loans at the sole discretion of the director.

80.5(5) *Unallowable uses.* Proceeds from any loans made under the program shall not be used for any of the following:

a. Compensation to employees, including any benefits.

b. Refinancing existing or future loans.

c. Working capital.

d. Payment of liabilities incurred prior to the origination of the loan, including unpaid taxes and money owed to creditors.

e. Charitable donations.

f. Purchase of real estate.

g. Purchase of a business unless the loan made under the program is leveraged with other sources of financing, including at least ten percent equity investment by the owner.

h. Purchase of vehicles unless the vehicle is a special-use vehicle that shall only be used for purposes related to the Iowa small business and personal use is not allowed.

i. Purchase of equipment unless the equipment is deployed and primarily used by the Iowa small business in Iowa throughout the life of the loan.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.6(83GA,SF2389) Eligibility. An Iowa small business is eligible to apply for a loan under the program provided the Iowa small business meets the following requirements:

80.6(1) The Iowa small business has a business plan and has received assistance from an Iowa small business development center or qualified public or nonprofit business consultant as defined by the department.

80.6(2) The Iowa small business is not in violation of environmental or worker safety laws or rules. This requirement shall apply only if the Iowa small business has been incorporated for at least two years.

80.6(3) The Iowa small business employs only workers legally authorized to work in the state.

80.6(4) The Iowa small business does not engage in the production, depiction or distribution of obscene material as defined in Iowa Code section 728.1.

80.6(5) The Iowa small business is not in bankruptcy or imminently contemplating filing for bankruptcy.

80.6(6) The Iowa small business has a demonstrated need for the funds and will use them for a purpose described in rule 261—80.1(83GA,SF2389).

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.7(83GA,SF2389) Application.

80.7(1) *General.* Applications will be evaluated at least monthly and in the order they are received. Iowa small businesses that desire to participate in the program shall submit to the administrator a standard application, which shall be made available on the department's Web site, www.lifechanging.com. In addition to the information requested in the application, Iowa small businesses applying under this rule may also be required to submit the following documents:

a. Business plan and summary.

b. Financial statements that show total assets and total liabilities.

c. Such other supporting documents as may be required by the administrator to demonstrate the Iowa small business's eligibility for the loan and its ability to repay the loan.

d. An energy audit of the facilities for which the loan is sought, if the loan is proposed to be used to reduce facility costs.

80.7(2) *Startup businesses.* In addition to the requirements described in subrule 80.7(1), Iowa small businesses that have been incorporated for less than two years must submit the following additional information unless the business can document that its assets are three times greater than its liabilities, including the loan sought under this program:

a. Contingent loan approval from a conventional loan source; or

b. Application to the Iowa microloan program for co-financing consideration. Such application must be made prior to submission of an application under this chapter.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.8(83GA,SF2389) Application review.

80.8(1) *Criteria.* The administrator shall evaluate applications based on the following criteria:

a. The quality of the Iowa small business's business plan and whether it projects a positive cash flow after the loan repayment.

b. Cash flow of the Iowa small business.

c. Credit score of the principal owner of the Iowa small business and any owners of the Iowa small business with an interest of greater than 25 percent in the Iowa small business. Applicants with a credit score lower than 625 shall not be considered for a loan under this program

d. Value and quality of collateral.

e. Education and experience of the owner of the Iowa small business related to owning and operating a business.

f. The quality and results of a marketing plan related to the Iowa small business.

g. The legal history, including any UCC-1 filings, of the principal owner of the Iowa small business and any owners with an interest of greater than 25 percent in the Iowa small business to the extent that history could negatively impact the business.

80.8(2) *Additional information.* The administrator or the department may require additional information from the Iowa small business in reviewing applications made under the program.

80.8(3) *Additional expertise.* The administrator and the department may use or procure the services of individuals with particular or specialized expertise in evaluating applications.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.9(83GA,SF2389) Recommendation; loan agreement.

80.9(1) *Recommendation.* Upon final review of the application, the administrator shall prepare loan closing documents, including a loan agreement, for those businesses the administrator recommends to participate in the program and deliver them, along with the business's file, to the department for its review and approval. The administrator shall recommend and make part of the proposed loan agreements requirements in addition to standard loan provisions when the business poses a higher risk.

80.9(2) *Loan agreement required.* The administrator shall prepare a loan agreement, which includes, but is not limited to, a description of the project to be completed by the business, the term of the loan, conditions to disbursement, a requirement for annual reporting to the department, and the repayment requirements of the business or other penalties imposed on the business in the event the business does not fulfill its obligations described in the loan agreement and other specific repayment provisions ("clawback provisions") to be established on a project-by-project basis.

80.9(3) *Security.* The department may take security for any loan. The form of such security may include but not be limited to one or more of the following:

a. Promissory note.

b. First real estate mortgage.

c. Assignment of option.

d. Assignment of lease.

e. Lien on personal property.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.10(83GA,SF2389) Repayment. All loans made under the program shall be subject to repayment as described in the loan agreement. Loans made under the program shall not be forgivable.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

261—80.11(83GA,SF2389) Default.

80.11(1) *Events of default.* The department may, for cause, determine that a recipient is in default under the terms of the loan agreement. The reasons for which the department may determine that the recipient is in default of the contract include, but are not limited to, any of the following:

a. Any material representation or warranty made by the recipient in connection with the application that was incorrect in any material respect when made.

b. A material change in the business ownership or structure occurs without prior written disclosure and the permission of the department.

c. A relocation or abandonment of the business during the term.

d. Expenditure of funds for purposes not described in the application or authorized in the agreement.

e. Failure of the recipient to make timely payments under the terms of the agreement, note or other obligation.

f. Failure of the recipient to perform or comply with the terms and conditions of the contract.

g. Failure of the recipient to comply with any applicable state rules or regulations.

h. Failure of the recipient to file the required annual report.

80.11(2) *Closures.* If a recipient closes any of its facilities within the state prior to receiving the incentives and assistance, the department may reduce or eliminate all or a portion of the loan assistance. If a business closes any of its facilities within the state after executing a contract to receive the loan assistance, the department may consider this an event of default and the business may be subject to repayment of all or a portion of the loan assistance that it has received.

80.11(3) *Department actions upon default.*

a. The department will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by recipients.

b. If the department determines that the recipient is in default, the department may seek recovery of all program funds plus interest, assess penalties, negotiate alternative repayment schedules, suspend or discontinue collection efforts, and take other appropriate action as the department deems necessary.

c. The department shall attempt to collect the amount owed. Negotiated settlements, write-offs or discontinuance of collection efforts is subject to final review and approval by the director.

d. If the department refers defaulted contracts to outside counsel for collection, then the terms of the agreement between the department and the outside counsel regarding scope of counsel's authorization to accept settlements shall apply.

[**ARC 8920B**, IAB 6/30/10, effective 6/11/10]

These rules are intended to implement 2010 Iowa Acts, Senate File 2389, sections 41 through 44.

[Filed Emergency ARC 8920B, IAB 6/30/10, effective 6/11/10]

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265—26.1(16) Statutory authority. The authority to provide loans to eligible applicants to assist in financing drinking water and wastewater treatment facilities and water pollution control projects is provided by Iowa Code sections 16.131 through 16.133.

265—26.2(16) Purpose. The Iowa finance authority provides financing to carry out the functions of the state revolving fund (SRF) loan programs. Under an agreement with the United States Environmental Protection Agency, the Iowa SRF is administered by the Iowa department of natural resources in partnership with the Iowa finance authority.
[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.3(16) Definitions.

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

"Clean Water Act" or *"CWA"* means the federal Water Pollution Control Act of 1972, as amended by the Water Quality Act of 1987.

"Commission" means the environmental protection commission of the Iowa department of natural resources.

"Common ownership" means the ownership of an animal feeding operation as a sole proprietor, or a majority ownership interest held by a person, in each of two or more animal feeding operations as a joint tenant, tenant in common, shareholder, partner, member, beneficiary, or other equity interest holder. The majority ownership interest is a common ownership interest when it is held directly, indirectly through a spouse or dependent child, or both.

"Department" or *"DNR"* means the Iowa department of natural resources.

"Director" means the director of the authority.

"DWSRF" means the drinking water state revolving fund.

"Eligible costs" means all costs related to the completion of a project as defined in the CWA and SDWA and 567—Chapters 40 and 90.

"EPA" means the United States Environmental Protection Agency.

"Intended use plan" or *"IUP"* means the program document identifying the intended uses of funds available for loans pursuant to the WPCSRF and the DWSRF.

"Nonpoint source" means any project described in Section 319 of the Clean Water Act.

"Recipient" means the entity receiving funds from the SRF.

"Safe Drinking Water Act" or *"SDWA"* means Title XIV of the federal Public Health Service Act, commonly known as the "Safe Drinking Water Act," as amended by the Safe Drinking Water Amendments of 1996.

"SRF" means the state revolving fund.

"WPCSRF" means the water pollution control state revolving fund.
[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.4(16) Project funding.

26.4(1) *Intended use plans/state project priority lists.* The state project priority lists shall include projects eligible for SRF loans as provided in 567—Chapters 44 and 92. The authority will consider the following when determining whether to provide a loan to an eligible recipient:

a. Recipient's financial capability to repay the loan and to provide operation and maintenance, replacement reserves, and, if required, debt service reserves;

b. Recipient's statement of willingness to accept all loan terms and conditions;

c. The priority of the project;

d. Funds available; and

e. The technical review and approval of the project by the department.

26.4(2) *Phased or segmented projects.* Loan funds for future portions of phased or segmented projects cannot be ensured, although subsequent segments of a project which has been awarded financial assistance will receive priority over other new projects. Loans made for separate phases or segments of a project will be administered separately.

26.4(3) *Loan adjustments.* Loan amounts may be adjusted to reflect eligible costs.

26.4(4) *Recipient record keeping.* The recipient shall maintain records that document all costs associated with the project. Moneys from the SRF and those contributed by the recipient shall be accounted for separately. Accounting procedures shall conform to generally accepted government accounting standards. The recipient shall agree to provide access to these records to the department, the authority, the state auditor, the state or EPA, and the Office of the Inspector General at the EPA. The recipient shall retain such records and documents for inspection and audit purposes for a period of three years from the date of the final loan payment.

26.4(5) *Site access.* The recipient shall agree to provide the department and the department's agent access to the project site at all times to verify that the loan funds are being used for the intended purpose and that the construction work meets all applicable state and federal requirements. Recipients shall also agree to provide the department periodic access to the project site for the duration of the loan to ensure that the project is being operated and maintained as designed.

26.4(6) *Cross-cutting laws.* Other federal and state statutes and programs may affect an SRF project. Loan agreements will include an assurance that a recipient will comply with all applicable federal and state requirements.

265—26.5(16) WPCSRF/DWSRF infrastructure construction loans.

26.5(1) *Loan agreements.* The authority will prepare a loan agreement when the application has been determined to be in compliance with the requirements of the CWA/SDWA and applicable state rules for SRF funding. The loan shall be accompanied by an enforceability opinion in a form acceptable to the authority and, if applicable, a bond counsel opinion as to the status of interest on the obligation, in a form acceptable to the authority. A copy of the current form of the loan agreement shall be provided to the applicant upon request.

26.5(2) *Loan rates and terms.* Loan terms for point source projects shall include the following:

a. *Interest rates.* Loan interest rates shall be established in the IUP and shall be established by taking into account factors including, but not limited to, the following:

(1) Interest rate cost of funds to the SRF;

(2) Availability of other SRF funds;

(3) Prevailing market interest rates of comparable non-SRF loans; and

(4) Long-term SRF viability.

b. *Loan initiation fee.* The loan initiation fee shall be established in the IUP. The fee shall be payable on the closing date of the loan agreement.

c. *Annual loan servicing fee.* The annual loan servicing fee shall be established in the IUP. The fee shall be due at the time of each annual principal repayment.

d. *Revenue pledge.* The recipient shall establish sufficient revenue sources that are acceptable to the director for the repayment of the loan. To ensure repayment of obligations according to the terms of the loan agreement, the recipient shall agree to impose, collect, and increase, if necessary, user charges, taxes, or other dedicated revenue sources identified for the loan repayment in order to maintain annual net revenues at a level equal to at least 110 percent of the amount necessary to pay debt service on all revenue obligations during the next fiscal year, provided, however, that, at the discretion of the director, the authority may allow other revenue sources and coverage of less than 110 percent as security. In case of loan default, the authority shall have authority to require revenue adjustment, through the manner described above, to collect delinquent loan payments.

e. *Security.* The loan shall be secured by a first lien upon the dedicated source of repayment which may rank on a parity basis with other obligations. The dedicated source of repayment is expected to be the net revenues of the recipient's system and the loan is expected to be secured by a first lien on said net revenues. Loans secured by revenues of a system may rank on a parity basis with other outstanding

obligations or, with the approval of the director, may be subordinate in right of payment to the recipient's other outstanding revenue obligations. Loans may also be secured by a general obligation of the recipient through the provision for a levy of taxes to repay the loan.

f. *Construction payment schedules.* An estimated construction drawdown schedule provided by the recipient shall be part of the loan agreement.

26.5(3) *Loan commitments.* A loan agreement shall be a binding commitment of the recipient.

26.5(4) *Purpose of payments.* The recipient shall use the proceeds of the WPCSRF/DWSRF loan solely for the purpose of funding the approved project.

26.5(5) *Costs.* All eligible costs must be documented to the satisfaction of the authority and the department before proceeds of the loan will be disbursed.

26.5(6) *Loan amount and repayment period.* All loans shall be made contingent on the availability of funds, the maximum loan term will be that allowed by EPA, and repayment of the loan must begin no later than one year after the project is completed or by the date specified in the loan agreement.

26.5(7) *Prepayment.* The loan may be prepaid, in whole or in part, on any date with the prior written consent of the authority.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.6(16) Planning and design loans.

26.6(1) *Timing of loan.* Prior to a recipient's execution of a loan agreement for project construction, funds may be loaned to the recipient to pay for initial eligible costs, including the cost of facility planning and design engineering.

26.6(2) *Duration.* Planning and design loans may not have a duration of longer than three years from their date of execution, unless the director provides written consent to a longer term.

26.6(3) *Interest rate.* The interest rate will be that rate specified in the most recent IUP.

26.6(4) *Rollover to construction loan.* All funds borrowed by the recipient as a planning and design loan may be financed as a part of a construction loan agreement upon expiration of the term of the planning and design loan.

26.6(5) *Repayment.* If the recipient does not execute an SRF construction loan, the planning and design loan shall be paid in full at the end of the three-year term, unless the loan term is extended by written consent of the director.

[**ARC 8079B**, IAB 8/26/09, effective 8/7/09]

265—26.7(16) Disadvantaged community status.

26.7(1) *Criteria for disadvantaged community status.* The authority, in conjunction with the department, may develop criteria to determine disadvantaged community status. Factors included in the criteria include, but are not limited to, the community's median household income and target user charges. Criteria to determine disadvantaged community status shall be established in the IUP.

26.7(2) *Interest rate.* Interest rates for disadvantaged communities shall be established in the IUP.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.8(16) WPCSRF nonpoint source set-aside loan programs.

26.8(1) *Nonpoint source loan assistance.* Loan assistance for nonpoint source projects shall be in the form of low-interest loans or through linked deposits or loan participations through participating lending institutions.

26.8(2) *Application for loan assistance.* Application for loan assistance may be made at any participating lending institution or submitted to the authority or the authority's agent, as applicable. A list of participating lending institutions will be made available by the authority, financial agent or other entity that the authority may use to administer this program. Application for loan assistance shall be made on forms provided by the authority or its agent.

26.8(3) *Project approval.* Each project must be approved by the appropriate environmental or conservation agency as determined by the department.

26.8(4) *Loan approval.* For linked deposit programs, the participating lending institution shall, upon receipt of a completed loan application form, either approve or deny the loan in accordance with the

program requirements. If the loan is approved, the lending institution shall notify the authority or its agent in order to reserve funds in that amount to ensure that funds are available at the time of disbursement. If the loan is denied, the lending institution shall notify the loan applicant, clearly stating the reasons for the loan denial. For low-interest loans with the authority, the authority, or its agent, shall notify the applicant of the loan approval or denial.

26.8(5) *Availability of funds.* Before acting on a loan application, the lending institution shall ensure that adequate funds are available for the project and that the completed project has been inspected and approved by the appropriate environmental or conservation agency as determined by the department.

26.8(6) *Property transfer.* In the event of property transfer from the applicant to another person or entity during the repayment period specified in the loan agreement, the balance of the loan shall be immediately due in full.

26.8(7) *Loan amount and period.* All loans shall be made contingent on the availability of funds in the applicable fund or set-aside program as indicated in the IUP. The minimum and maximum loan amounts that will be considered are dependent on project type and are set forth as follows:

Type of Project	Type of Assistance	Minimum Loan Amount	Maximum Outstanding Balance	Maximum Loan Term	Project Approval Agency
General Nonpoint Source	Low-interest loans, Linked deposit or Loan participations	$5,000	No maximum	20 years	DNR
Local Water Protection	Linked deposit	$5,000	$500,000 per common ownership	10 years	Division of Soil Conservation
Livestock Water Quality Facilities	Linked deposit	$10,000	$500,000 per common ownership	15 years*	Division of Soil Conservation
Onsite Wastewater Systems Assistance	Linked deposit	$2,000	No maximum	10 years	County

*If the loan is made only for preparation of a comprehensive nutrient management plan, the loan period shall not exceed 5 years.

26.8(8) *Prepayment.* For direct loans, prepayment of the loan principal in whole or in part shall be allowed without penalty.

26.8(9) *Loan adjustments.* If the eligible costs exceed the loan amount, the recipient may request an increase in the loan amount. The lending institution is authorized to execute a loan for a principal amount of up to 10 percent above the amount of the loan application if the eligible costs exceed the application amount. To determine the appropriate action, the authority will evaluate the request by considering available moneys in the fund as well as the financial risk. Should the eligible costs be less than the loan amount, the loan shall be appropriately adjusted.

26.8(10) *Disbursement of funds.* Funds shall be disbursed in accordance with the loan agreement. The loan agreement may allow for periodic disbursement of funds.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10; **ARC 8906B**, IAB 6/30/10, effective 6/10/10]

265—26.9(16) Termination and rectification of disputes.

26.9(1) *Termination.* The authority shall have the right to terminate any loan if a term of the agreement has been violated. Loans are subject to termination if construction has not begun within one year of the execution of a loan agreement. The director will establish a repayment schedule for funds already loaned to the recipient. Every termination must be in writing.

26.9(2) *Rectification and disputes.* Failure of the recipient to implement the approved project or to comply with the applicable requirements constitutes grounds for the authority, the authority's agent, or

the participating lending institution to withhold loan disbursements. The recipient is responsible for ensuring that the identified problem(s) is rectified. Once the deficiency is corrected, the loan funds can be released. A recipient that disagrees with the director's withholding of loan funds may request a formal review of the action. The recipient must submit to the director a written request for a formal review of the action within 30 days of receiving notice that loan disbursements will not be released.

These rules are intended to implement Iowa Code sections 16.5(17) and 16.133.

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CHAPTER 29
JUMP-START HOUSING ASSISTANCE PROGRAM

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

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

"Authority" means the Iowa finance authority.

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

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

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

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

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

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

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

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

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

"FEMA" means the Federal Emergency Management Agency.

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

"Local government participant" means:

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

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

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

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

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

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

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

29.3(1) *Allocation criteria.*

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

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

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

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

1. Have not received any moneys under the program;

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

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

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

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

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

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

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

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

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

265—29.4 Reserved.

265—29.5(16) Eligible uses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09; **ARC 8907B**, IAB 6/30/10, effective 6/10/10]

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

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

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

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

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

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

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

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

c. That portion of the repayment due for an energy efficiency assistance loan made under subrule 29.5(3) for which the eligible resident provides documentation that the assistance was expended for the purpose for which it was awarded.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09; **ARC 8323B**, IAB 12/2/09, effective 11/4/09; **ARC 8546B**, IAB 2/24/10, effective 3/31/10; **ARC 8907B**, IAB 6/30/10, effective 6/10/10]

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

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

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

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

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

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

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

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

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

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

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CHAPTER 32
IOWA JOBS PROGRAM

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

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

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

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

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

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

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

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

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

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

"Local infrastructure" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32.4(6) *Application procedure.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. General scoring criteria.

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

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

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09; **ARC 8103B**, IAB 9/9/09, effective 8/19/09; **ARC 8327B**, IAB 12/2/09, effective 11/4/09; **ARC 8456B**, IAB 1/13/10, effective 2/17/10; **ARC 8545B**, IAB 2/24/10, effective 3/31/10]

265—32.5(16) Noncompetitive grants.

32.5(1) Pursuant to 2010 Iowa Acts, Senate File 2389, section 10(4)*"a,"* the board shall award $30,900,000 as follows for disaster relief and mitigation renovation and construction projects, notwithstanding any limitation on the state's percentage participation in funding as contained in Iowa Code section 29C.6(17):

a. To a county with a population between 189,000 and 196,000 in the last preceding certified federal census for the renovation and expansion of an administrative office building: $4,400,000.

b. To a city with a population between 120,500 and 120,800 in the last preceding certified federal census, for the following projects:

(1) For renovation of an existing public building to make the building useful for city department offices: $4,400,000.

(2) For flood mitigation or renovation in and around an existing courthouse: $2,000,000.

c. To a city with a population between 198,000 and 199,000 in the last preceding certified federal census to be allocated as follows:

(1) For site acquisition, design, engineering, and construction of a fire training and logistics center: $3,000,000.

(2) For land acquisition, design, and construction of sewers, structures, and pumping facilities necessary to separate and convey sewer flow within the riverpoint service area: $1,250,000.

(3) For land acquisition, design, and construction of sewers, structures, and pumping facilities necessary to separate or convey sewer flow within the Court Avenue service area: $3,050,000.

(4) For bank stabilization, stream bed stabilization, and erosion control on highly erodible ground that is impacting utilities, road infrastructure, and water quality: $700,000.

(5) To improve utilization of two of the wastewater reclamation authority's existing equalization basins for the control of peak flows during wet weather events in the authority's sewer system: $500,000.

d. For a publicly owned acute care teaching hospital located in a county with a population of over 350,000, for the construction and renovation of patient access and care facilities, equipment replacement and upgrades, and other infrastructure improvements: $1,000,000.

e. For a city with a population between 98,300 and 98,400 in the last preceding certified federal census, for flood protection, replacement, and construction improvements to a recreational sports facility: $1,050,000.

f. For a city with a population between 68,700 and 68,800 in the last preceding certified federal census, for a public works building that will allow the city to provide for disaster-related services: $5,000,000.

g. For a city with a population between 62,100 and 62,250 in the last preceding certified federal census, for the demolition, relocation, and reconstruction of a public wastewater treatment plant and the development of a public green space: $2,000,000.

h. For a city with a population between 2,545 and 2,555 in the last preceding certified federal census, for a streetscape project that reconstructs existing horizontal infrastructure and lighting systems utilizing sustainable development practices: $1,175,000.

i. For a city with a population between 2,200 and 2,220 in the last preceding certified federal census, for construction of a public city building: $475,000.

j. For a city with a population between 2,558 and 2,565 in the last preceding certified federal census, for the installation of backflow prevention devices for the city's storm sewer system: $600,000.

k. For a city with a population between 6,875 and 6,890 in the last preceding certified federal census, for the construction of grade control structures and associated grading to mitigate future water damage to residential structures: $300,000.

32.5(2) Noncompetitive grant awards are contingent upon submission of a plan for each project by the applicable county or city governing board to the Iowa jobs board no later than September 1, 2010, on a form to be prescribed by the authority, detailing information requested thereon, such as a description of the project, the plan to rebuild, and the amount or percentage of federal, state, local, or private matching moneys which will be or have been provided for the project, and similar information.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09; **ARC 8905B**, IAB 6/30/10, effective 6/10/10]

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

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

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

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

32.6(4) *Use of Iowa jobs Web site.* All positions that need to be filled for a project shall be posted on Iowa workforce development's Iowa jobs Web site: www.iowajobs.org/.

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

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

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

265—32.8(16) Grant awards. The Iowa jobs board may fund a component of a proposed project if the entire project does not qualify for funding. The board shall review awards made to ensure geographic diversity. In order to promote geographic diversity, the board may defer grant decisions on applications from areas which have received previous grant awards to allow applications from other parts of the state to be considered. In the event that a competitive grant recipient, prior to execution of an Iowa jobs grant agreement, is awarded a federal grant for its project, in whole or in part, which federal grant, or the possibility thereof, was not disclosed as part of the recipient's application, the board may withdraw all or part of the Iowa jobs program grant.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09; **ARC 8455B**, IAB 1/13/10, effective 12/14/09; **ARC 8626B**, IAB 3/24/10, effective 4/28/10]

265—32.9(16) Administration of awards.

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

32.9(2) Grant agreement.

a. Following the board's determination that a competitive grant application should be approved, authority staff shall propose a draft grant agreement to the recipient. Within 30 days of either transmission of the proposed grant agreement to the recipient or transmission of notice of how the proposed grant agreement may be accessed by the recipient via the Internet, the recipient shall notify the authority as to whether the recipient will execute the proposed agreement or whether the recipient would prefer to negotiate a different agreement. If the recipient elects to execute the proposed agreement, or if the

recipient fails to make a timely election, the authority shall prepare and transmit to the recipient on behalf of the board a final contract for execution.

b. If the recipient elects to negotiate a different agreement, the recipient shall, at the time it makes such election, notify the authority of the requested changes to the proposed grant agreement. The authority shall consider the requested changes and may make such revisions to the proposed agreement as the authority determines to be prudent and in the best interests of the Iowa jobs program and the state of Iowa under the circumstances.

c. Once the authority and the recipient have reached an agreement, the authority shall prepare and transmit to the recipient on behalf of the board a final contract, subject to approval by the board.

d. If the authority and the recipient are unable to reach an agreement, the authority shall, with the board's approval, draft and transmit to the recipient on behalf of the board a final contract consisting of the Iowa jobs board's best and final offer.

32.9(3) The recipient must execute and return the contract to the Iowa jobs board within 45 days of transmittal of the final contract from the Iowa jobs board. Failure to do so may be cause for the Iowa jobs board to terminate the award.

32.9(4) Certain projects may require that permits or clearances be obtained from other state, local, or federal agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

32.9(5) Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

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

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09; **ARC 8455B**, IAB 1/13/10, effective 12/14/09; **ARC 8626B**, IAB 3/24/10, effective 4/28/10]

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

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CHAPTER 38
IOWA JOBS II PROGRAM

265—38.1(16) Purpose. The Iowa jobs board is charged by the Iowa legislature and the governor with establishing, overseeing and providing approval of the administration of the Iowa jobs II program. The board will encourage and support public construction projects relating to disaster prevention.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.2(16) Definitions. When used in this chapter, the following definitions apply unless the context otherwise requires:

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

"Board" means the Iowa jobs board as established in 2009 Iowa Code Supplement section 16.191.

"Disaster" means an occurrence that causes widespread or extensive destruction and distress, including but not limited to floods, tornadoes, blizzards, fires, earthquakes, terrorist attacks, aviation and environmental accidents, and similar catastrophes.

"Disaster prevention" means the prevention, reduction (in number or in scope), mitigation, or amelioration of future disasters or the harm caused thereby.

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

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

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

"Iowa jobs program review committee" or *"review committee"* means the committee established by 2009 Iowa Code Supplement section 16.195.

"Local infrastructure" means projects relating to disaster prevention. "Local infrastructure" does not include routine, recurring maintenance or operational expenses or the leasing of a building, appurtenant structure, or utility without a lease-purchase agreement.

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

"Program" means the Iowa jobs II program established in 2010 Iowa Acts, Senate File 2389, section 88.

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

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

"Smart planning principles" means the principles set forth in division VII of 2010 Iowa Acts, Senate File 2389.

"Sustainability" means the use, development, and protection of resources at a rate and in a manner that enable people to meet their current needs while allowing future generations to meet their own needs; "sustainability" requires simultaneously meeting environmental, economic and community needs.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.3(16) Allocation of funds. All Iowa jobs II funds shall be awarded and used as specified in 2010 Iowa Acts, Senate File 2389, division VII, and these rules. If a city or county that is awarded funds under the program has not begun drawing funds within one year of the date of the award, the grant shall terminate and no funds shall be disbursed unless the board, in its sole discretion, prior to the first anniversary of the date of the award, grants an extension due to extraordinary circumstances. Any portion of an amount allocated for projects that remains unexpended or unencumbered one year after the allocation has been made by the board may be reallocated by the board to another project category, at the discretion of the board. All bond proceeds shall be expended within three years from when the allocation was initially made. The total amount of allocations for disaster prevention projects (pursuant to the local

infrastructure competitive grant program) shall not exceed $30 million for the fiscal year beginning July 1, 2010.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.4(16) Iowa jobs II program. The board shall assist in the development and completion of public construction projects relating to disaster prevention by overseeing and providing approval of the administration of the Iowa jobs II grant program, as set forth herein.

38.4(1) *Eligible applicants.* Eligible applicants for Iowa jobs II local infrastructure competitive grant program funds shall be Iowa cities and counties that apply smart planning principles and guidelines pursuant to division VII of 2010 Iowa Acts, Senate File 2389. A city or county shall be deemed to apply smart planning principles if it has committed by resolution promptly to perform a review to determine the potential advantages and disadvantages to the city or county of adopting a comprehensive plan or, if the city or county already has a comprehensive plan, of amending that comprehensive plan. By such resolution, to be eligible, the city or county must also commit, in the event it is awarded a grant under the Iowa jobs II local infrastructure competitive grant program, to complete the adoption or amendment of its comprehensive plan utilizing smart planning principles within three years of the award of such grant.

38.4(2) *Eligible projects and forms of assistance.* For a project to be eligible to receive a competitive grant under the program, the project must be a public construction project relating to disaster prevention to be located in the state of Iowa which will have a demonstrated substantial local, regional, or statewide economic impact. Financial assistance shall be awarded only in the form of grants. In the event that a project has multiple intended uses or purposes, of which only a portion is related to disaster prevention, then only that portion of the project intended or designed for disaster prevention shall be deemed eligible.

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

(1) Up to 90 percent of the first $500,000 in total cost of the development and completion of a public construction project relating to disaster prevention;

(2) Up to 50 percent of all additional costs of such project;

(3) An applicant or a combination of applicants for a project within the same county shall not be awarded more than 40 percent of the funds available under the program.

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

38.4(3) *Ineligible projects.* The board shall not approve an application for a competitive grant for the following purposes:

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

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

38.4(4) *Threshold application requirements.* To be considered for a competitive grant, an application shall meet all of the following threshold requirements:

a. Prior to filing an application, the applicant must file, on the form and in the manner prescribed by the authority, a notice of intent to apply not less than 10 days prior to submitting its application;

b. The application must be submitted by an eligible applicant via the board's application Web site (http://www.ijobsiowa.gov) prior to the applicable deadline;

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

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

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

f. The applicant must document its application of smart planning principles; and

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

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

38.4(5) *Application procedure.*

a. Applications shall be reviewed and scored in rounds. The deadline for submission for the first round of applications shall be August 2, 2010. Subsequent rounds, if any, shall be at the discretion of the board as funding is available.

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

c. The review committee members will score the applications according to the criteria set forth in subrule 38.4(6), and authority staff shall compile the scores. To be eligible for a grant, a proposed project must receive a minimum score of at least 100 points on the scoring criteria listed in paragraphs 38.4(6)*"a"* to *"e."* The review committee shall meet to review the ratings for each round of applications. Those applications meeting the minimum criteria shall be referred to the Iowa jobs board with a recommendation of final approval, denial, or deferral.

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

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

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

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

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

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

38.4(6) *Application review criteria.* The Iowa jobs program review committee shall evaluate and rank applications based on the following criteria:

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

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

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

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

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

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

(1) (0-15 points) A financial analysis of the project, which shall include a description of sources of funding, project budget, and detailed projections of the project's revenues and expenses for the projected useful life of the project;

(2) (0-15 points) An analysis of the operational plan, which shall provide detailed information about how the proposed project will be operated and maintained, including a time line for implementing the project;

(3) (0-10 points) The extent to which the applicant will use funds other than an Iowa jobs II grant to fund its project. For each percentage (rounded to the nearest percentage divisible by 10) of the total projected project cost that is to be funded with non-Iowa jobs II grant funds, the project shall receive one point.

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

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

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

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

● Efficient and effective use of land resources and existing infrastructure by encouraging compact development in areas with existing infrastructure or capacity to avoid costly duplication of services and costly use of land; conservation of open space and farmland and preservation of critical environmental areas; and promotion of the safety, livability, and revitalization of existing urban and rural communities. Compact development maximizes public infrastructure investment and promotes mixed uses, greater density, bicycle and pedestrian networks, and interconnection with the existing street grid.

● Provision for a variety of transportation choices, including public transit and pedestrian and bicycle traffic.

● Construction and promotion of developments, buildings, and infrastructure that conserve natural resources by reducing waste and pollution through efficient use of land, energy, water, and materials.

● Capture, retention, infiltration and harvesting of rainfall using storm water best management practices such as permeable pavement, bioretention cells, bioswales, and rain gardens to protect water resources.

● The extent to which project design, construction, and use incorporate renewable energy sources including, but not limited to, solar, wind, geothermal, and biofuels, and support the following state of Iowa plans and goals: (1) office of energy independence's Iowa energy independence plan; and (2) general reduction of greenhouse gas emissions.

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

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

1. In the case of new construction, whether the project is designed to meet the current state building energy code. The application for the project must include a letter from the engineer or architect to IFA certifying whether the proposed construction meets the current state building energy code. Additionally, the application should address whether the proposed project is designed to meet energy star standards.

If the project is of such a nature that the current state building energy code does not apply to it, the letter shall so state.

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

d. Benefits for disaster prevention (0-40 points). The likely benefits for disaster prevention of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, whether the proposed project is designed to prevent, reduce (in number or in scope), mitigate, or ameliorate future disasters or the losses therefrom.

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

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

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

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

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

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

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

f. General scoring criteria.

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

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

[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.5(16) General grant conditions. As a condition of receipt of Iowa jobs II funds, recipients shall agree, at a minimum, to all of the following:

38.5(1) *Documentation of jobs created or retained.* Following the receipt of grant funds pursuant to this chapter and for two years following the completion of the project, each recipient shall report to the authority quarterly the actual number of jobs created as a result of the project along with other information relating to the quality of such jobs, including hours and wages, as requested by the authority.

38.5(2) *Recipient obligations.* In the event a recipient fails to comply with the requirements of this program or the recipient's grant agreement, the board may cancel the recipient's grant and require the return of any grant funds previously disbursed pursuant to this program. Recipients shall agree to hold harmless and to indemnify the Iowa jobs board, the authority, the state of Iowa, and their officers,

employees and agents from any claims, costs or liabilities arising out of the development or operation of the project.

38.5(3) *Grant acknowledgment.* Each project shall recognize in a prominent location and manner the fact that the project was made possible, in part, through a grant from the Iowa jobs program. During the construction period the recognition (including a display of the Iowa jobs logo) may be located on temporary signage. The completed project shall feature a permanent acknowledgment, such as a plaque or a similar commemoration. Other benefactors of the project may be similarly acknowledged as well.

38.5(4) *Use of Iowa jobs Web site.* All positions that need to be filled for a project shall be posted on Iowa workforce development's Iowa jobs Web site: www.iowajobs.org/.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.6(16) Calculation of jobs created. For purposes of this chapter, new employment positions created and filled (or to be created and filled) as a result of the project and existing positions that would not have been continued were it not for Iowa jobs funding shall be counted when estimating the number of jobs to be created during the application process and when counting the number of actual jobs created in post-grant reporting. Both permanent and temporary positions filled by the grantee, a contractor, or a subcontractor (or sub-subcontractor, etc.), including construction work, shall be counted. To be counted, a position must be compensated. Indirect jobs and induced jobs shall not be counted.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.7(16) Grant awards. The Iowa jobs board may fund a component of a proposed project if the entire project does not qualify for funding. The board shall review awards made to ensure geographic diversity. In order to promote geographic diversity, the board may defer grant decisions on applications from areas which have received previous grant awards to allow applications from other parts of the state to be considered. In the event that a competitive grant recipient, prior to execution of an Iowa jobs II grant agreement, is awarded a federal grant for its project, in whole or in part, which federal grant, or the possibility thereof, was not disclosed as part of the recipient's application, the board may withdraw all or part of the Iowa jobs II program grant.
[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

265—38.8(16) Administration of awards.

38.8(1) A grant agreement shall be executed between successful applicants and the Iowa jobs board. These rules and applicable state laws and regulations shall be part of the contract. The board reserves the right to negotiate wage rates as well as other terms and conditions of the contract.

38.8(2) Grant agreement.

a. Following the board's determination that a competitive grant application should be approved, authority staff shall propose a draft grant agreement to the recipient. Within 30 days of either transmission of the proposed grant agreement to the recipient or transmission of notice of how the proposed grant agreement may be accessed by the recipient via the Internet, the recipient shall notify the authority as to whether the recipient will execute the proposed agreement or whether the recipient would prefer to negotiate a different agreement. If the recipient elects to execute the proposed agreement, or if the recipient fails to make a timely election, the authority shall prepare and transmit to the recipient on behalf of the board a final contract for execution.

b. If the recipient elects to negotiate a different agreement, the recipient shall, at the time it makes such election, notify the authority of the requested changes to the proposed grant agreement. The authority shall consider the requested changes and may make such revisions to the proposed agreement as the authority determines to be prudent and in the best interests of the Iowa jobs II program and the state of Iowa under the circumstances.

c. Once the authority and the recipient have reached an agreement, the authority shall prepare and transmit to the recipient on behalf of the board a final contract, subject to approval by the board.

d. If the authority and the recipient are unable to reach an agreement, the authority shall, with the board's approval, draft and transmit to the recipient on behalf of the board a final contract consisting of the Iowa jobs board's best and final offer.

38.8(3) The recipient must execute and return the contract to the Iowa jobs board within 45 days of transmittal of the final contract from the Iowa jobs board. Failure to do so may be cause for the Iowa jobs board to terminate the award.

38.8(4) Certain projects may require that permits or clearances be obtained from other state, local, or federal agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

38.8(5) Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

38.8(6) Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions, and significant alterations that change the scope, location, objectives or scale of an approved project. Amendments must be requested in writing by the recipient and are not considered effective until approved by the Iowa jobs board and confirmed in writing by IFA staff following the procedure specified in the contract between the recipient and the Iowa jobs board.

[**ARC 8890B**, IAB 6/30/10, effective 6/10/10]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2010 Iowa Acts, Senate File 2389, sections 84 to 88.

[Filed Emergency ARC 8890B, IAB 6/30/10, effective 6/10/10]

HUMAN SERVICES DEPARTMENT[441]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—36.5 Reserved.

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

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

These rules describe the nursing facility quality assurance assessment authorized by 2009 Iowa Code Supplement chapter 249L. The rules explain how the assessment is determined and paid.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10]

441—36.6(249L) Assessment.

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

a. Nursing facilities operated by the state.

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

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

36.6(2) *Assessment level.*

a. Nursing facilities with 50 or fewer licensed beds are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

b. Nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

c. Nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

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

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

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

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

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

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

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

36.7(4) A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue. If the department determines that good cause is shown for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.7(5) For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the

quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.
[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10]

441—36.8 and **36.9** Reserved.

These rules are intended to implement 2009 Iowa Code Supplement chapter 249L.

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

These rules describe the hospital health care access assessment authorized by 2010 Iowa Acts, Senate File 2388, enacted by the Eighty-third General Assembly. The rules explain how the assessment is determined and paid.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10]

441—36.10(83GA,SF2388) Application of assessment.

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

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

a. Contractual adjustments,
b. Charity care,
c. Bad debt,
d. Medicare revenue, or
e. Other revenue derived from sources other than hospital operations including but not limited to:
(1) Nonoperating revenue,
(2) Other operating revenue,
(3) Skilled nursing facility revenue,
(4) Physician revenue, and
(5) Long-term care revenue.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10]

441—36.11(83GA,SF2388) Determination and payment of assessment. The assessment shall be determined and paid as follows:

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

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

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

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

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

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

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

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

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10]

441—36.12(83GA,SF2388) Termination of health care access assessment. If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10]

These rules are intended to implement 2010 Iowa Acts, Senate File 2388.

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TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

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

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

441—75.1(249A) Persons covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Failure to provide information, or

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

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

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. The state with the adoption assistance agreement:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Meets one of the following:

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

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

3. Participates in a state perinatal program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.1(35) *Medically needy persons.*

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

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

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

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

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

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

b. *Resources and income of all persons considered.*

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

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

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

c. *Resources.*

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

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

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

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

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

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

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

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

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

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

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

e. Medically needy income level (MNIL).

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

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

Each additional person $116

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

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

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

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

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

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

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

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

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

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

g. Spenddown calculation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Care in an institution for mental disease.

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

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

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

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

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

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

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

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

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

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

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

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

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

a. The person is not otherwise eligible for Medicaid.

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

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

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

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

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

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

75.1(39) *Working persons with disabilities.*

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

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

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

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

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

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

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

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

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

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

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$33
180% of Federal Poverty Level	$53
220% of Federal Poverty Level	$73
250% of Federal Poverty Level	$94
280% of Federal Poverty Level	$109
310% of Federal Poverty Level	$129
340% of Federal Poverty Level	$154
370% of Federal Poverty Level	$188
400% of Federal Poverty Level	$221
430% of Federal Poverty Level	$255
460% of Federal Poverty Level	$295
510% of Federal Poverty Level	$342
590% of Federal Poverty Level	$396
680% of Federal Poverty Level	$457
775% of Federal Poverty Level	$524
900% of Federal Poverty Level	$608

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

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

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

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

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

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

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

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

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

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

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

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

(8) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Medical assistance shall be available to people who:

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

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

(3) Are under the age of 65.

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

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

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

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

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

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

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

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

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

2. Either:

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Denied presumptive eligibility by a qualified provider.

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

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

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

a. Eligibility. The following are eligible for assistance under this coverage group:

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

(2) Women who are of childbearing age, are capable of bearing children but are not pregnant, and have income that does not exceed 200 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

b. Application.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The child is under 19 years of age.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—75.4(249A) Medical assistance lien.

75.4(1) When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, to all monetary claims which the member may have against third parties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.4(4) Third party and provider responsibilities.

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

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

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

75.4(5) Department's lien.

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

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

lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

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

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

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

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

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

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

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

75.5(1) Determining income from property.

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

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

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

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

b. *Spouses institutionalized and living together.* Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

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

c. *Spouses institutionalized and living apart.* Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately

for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

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

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

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2)*"d"* shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the

following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

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

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. *Eligibility.* A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. *Definition.* "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. *Estate recovery.* An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35and chapter 514H.

[**ARC 8443B**, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term "well-established religious objections" means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

"Incapable of expressing intent" shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

"Institution" shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) *Determining residency.* Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person's state of residence is:

1. That of the parent applying for Medicaid on the person's behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
2. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
4. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person's parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is in institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to

have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;
2. Granted asylum under Section 208 of the Immigration and Nationality Act;
3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;
5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

(3) An alien child under the age of 19 who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

(4) A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act.

(5) An alien who has been granted asylum under Section 208 of the Immigration and Nationality Act.

(6) An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0466 (Spanish);
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS);

c. Except as provided in paragraph *"f,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d," "e,"* or *"i."* A reference to a form in paragraph *"d"* or *"e"* includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)*"i"*(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. Medicaid shall not be approved for an applicant or continued for a member who has already received benefits during any portion of a reasonable period until satisfactory documentation is provided.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph *"d," "e,"* or *"i."* The retroactive months are outside the "reasonable period" during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or
2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is eligible for child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is eligible for adoption or foster care assistance funded under Part E of Title IV of the federal Social Security Act; or

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

g. If no other identity documentation allowed by subparagraph 75.11(2)*"e"*(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)*"e"*(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph *"d"* or *"e,"* satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph *"d"* or *"e."*

75.11(3) *Deeming of sponsor's income and resources.*

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and, in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor's income and resources no longer applies.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7932B**, IAB 7/1/09, effective 7/1/09; **ARC 8096B**, IAB 9/9/09, effective 10/14/09; **ARC 8642B**, IAB 4/7/10, effective 6/1/10; **ARC 8786B**, IAB 6/2/10, effective 6/1/10]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase "inmate of a public institution" is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

This rule is intended to implement Iowa Code section 249A.3.

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for

the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that

because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative

father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

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

[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds $500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. Clients receiving a VA pension. The amount of $90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is

made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

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

[**ARC 8444B**, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) *Multiple pregnancy.* If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) *Cost of examination.* When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children who are eligible only in a retroactive month.

e. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)*"c."*

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[**ARC 8786B**, IAB 6/2/10, effective 6/1/10]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Redeterminations of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2)*"b."*

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

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

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

(1) There was a serious illness or death of the parent or a member of the parent's family.

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

(3) The parent offers a good cause beyond the parent's control.

(4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.*

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The

department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall be completed whenever:

(1) A premium rate, deductible, or coinsurance changes,

(2) A person covered under the policy loses full Medicaid eligibility,

(3) Changes in employment or hours of employment affect the availability of health insurance,

(4) The insurance carrier changes,

(5) The policyholder leaves the Medicaid home, or

(6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16)*"a,"* shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. *Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. *Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. *Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. *Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and

community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July

1, 2010, through June 30, 2011, this average statewide cost shall be $4,842.72 per month or $159.30 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either

by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)*"c"*);
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)*"d"*); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.*

a. The entire amount used to purchase an annuity on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in subparagraphs (1) through (3) of this paragraph and also meets the condition described in subparagraph (4).

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(4) Iowa is named as the remainder beneficiary either:

1. In the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

2. In the second position after the community spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

b. Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in 75.23(9)*"a"* were met.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8444B**, IAB 1/13/10, effective 3/1/10; **ARC 8898B**, IAB 6/30/10, effective 7/1/10]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of

the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2010, to June 30, 2011, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $4,422 per month.

(2) and (3) Rescinded IAB 7/7/04, effective 7/1/04.

(4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $23,845 per month.

(5) The average statewide charge to a resident of a mental health institute is $16,720 per month.

(6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $5,010 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.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8898B**, IAB 6/30/10, effective 7/1/10]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible" shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Member" shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, "member" shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member."

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of assets" shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

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

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

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

441—75.28 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Needy specified relative" means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member's circumstances comes to the attention of a staff member.

75.52(3) *Forms.*

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) *Client responsibilities.* For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*

(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.

(2) Change of mailing or living address.

(3) Sources of income.

(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.

(2) The mailing or living address changes.

(3) A source of income changes.

(4) A health insurance premium or coverage change is effective.

(5) Of any change in income.

(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[**ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

(2) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1)*"b"* as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)*"n"* or *"o,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)*"c"*reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine

the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)*"d"* and 75.57(7)*"ag."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"*75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The department shall return all verification to the applicant or member.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic

needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month

following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)*"b"* and 75.57(1)*"d."*

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5)

shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)*"f."*

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified

at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."*

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any

income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income

shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent

children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) *Exclusions from the eligible group.* In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) *Needs, income, and resource exclusions.* The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) *Medicaid entitlement.* Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2)*"a," "b,"* and *"c."*

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Effective July 1, 2009, providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to 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.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $21.57 per half-day, $42.93 per full day, or $64.38 per extended day if no Veterans Administration contract. For intellectual disabilities waiver: County contract rate or, in the absence of a contract rate, $28.73 per half-day, $57.36 per full day, or $73.13 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $48.29. Ongoing monthly fee $37.56.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%. For intellectual disabilities waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.31 per hour.
5. Nursing care	For elderly and intellectual disabilities waivers: Fee schedule as determined by Medicare.	For elderly waiver: $80.85 per visit. For intellectual disabilities waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $80.85 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.52 per half hour.
8. Home-delivered meals	Fee schedule	$7.52 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1,010 lifetime maximum. For intellectual disabilities waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.04 per unit.
13. Assistive devices	Fee schedule	$107.30 per unit.
14. Senior companion	Fee schedule	$6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$19.70 per hour not to exceed the daily rate of $113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $35.79 per day.
Individual	Fee agreed upon by consumer and provider	$13.13 per hour not to exceed the daily rate of $76.60 per day.
16. Counseling		
Individual:	Fee schedule	$10.52 per unit.
Group:	Fee schedule	$42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour, $76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment:		
Activities to obtain a job:		

Provider category	Basis of reimbursement	Upper limit
Job development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.31 per hour for personal care. Maximum of $6.04 per hour for services in an enclave setting. Total not to exceed $2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6,060 per year.
21. Behavioral programming	Fee schedule	$10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	$42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $36.50 per day. For the intellectual disabilities waiver: County contract rate or, in absence of a contract rate, $47.01 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	$12.79 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $12.88 per hour, $31.35 per half-day, or $62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour.
29. In-home family therapy	Fee schedule	$91.29 per hour.

Provider category	Basis of reimbursement	Upper limit
30. Financial management services	Fee schedule	$64.01 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	$14.77 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).

Provider category	Basis of reimbursement	Upper limit
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$4.34 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's

hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph *"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;

3. A current listing of charges; and

4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If the federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments fund pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between $51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.

(2) Promotional items.

(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. *Fee schedule.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. *Supplemental payments.* Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph *"g."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph *"g."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from

the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after July 1, 2010, the professional dispensing fee is $4.34 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding 100 percent of adjusted actual costs shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 100 percent of actual costs 30 days after notice is given by the department will have the revenues over 100 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, shall mean the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that

incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services established pursuant to 79.1(1)*"c."*

		For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital

and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) Effective July 1, 2009, a unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a

reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or

2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim

rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.

(2) Extent of violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.

(5) Prior provision of provider education.

(6) Provider willingness to obey program rules.

(7) Whether a lesser sanction will be sufficient to remedy the problem.

(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)*"c"* are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,

b. The known dollar value of the discrepancies or violations,

c. The method of computing the dollar value,

d. Notification of further actions to be taken or sanctions to be imposed by the department, and

e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"*

441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.

2. Psychological examination report and notes.

(9) Clinic services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:
1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:
1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:
1. Physician orders.

2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Remedial services and rehabilitation services for adults with a chronic mental illness:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:
1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:
1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:
1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:
1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:
1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:
1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:
1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. *Use of statistical sampling techniques.* The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. *Disagreement with sampling results.* When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

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

79.7(6) *Duties.*

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. *Council.* The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to

whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according

to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the

person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Surveillance and Utilization Review Services Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

441—79.16(249A) Payment reductions pursuant to executive order. Rescinded IAB 6/30/10, effective 7/1/10.

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1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

7 July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

PREAMBLE

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill. Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill. These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and client eligibility requirements.

DIVISION I
PSYCHIATRIC HOSPITALS

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

(1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.

(2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.

(3) Is accredited as a psychiatric facility by the Joint Commission on the Accreditation of Health Care Organizations or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the division of behavioral, developmental, and protective services for families, adults, and children of the department.

b. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B) or shall be licensed in another state as a hospital, shall be accredited by the Joint

Commission on the Accreditation of Health Care Organizations, the Commission of Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals, and shall meet federal service requirements.

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior approval by the bureau of managed care and clinical services and shall be approved only if special services are not available in Iowa facilities as determined by the division of behavioral, developmental, and protective services for families, adults, and children.

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) *Certification of need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.5(249A) Client participation.

85.5(1) *Before July 2005.* For months before July 2005, the resident shall be liable to pay client participation toward the cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

85.5(2) *July 2005 and after.* Effective with the month of July 2005, the resident shall not be liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. *Active treatment.* Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. *Individual plan of care.* An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. *Interdisciplinary team.* The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) *Reimbursement formula.* Acute care in psychiatric hospitals shall be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act and amendments to that Act, Medicare regulations found in the Health Insurance Regulation Manual (HIRM-1), and General Instructions-Health Insurance Manual sections 10, 11, 12 and 15 when applicable.

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9, as amended to December 2, 1996, and 42 CFR 447.250 as amended to September 23, 1992. Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the Iowa Medicaid enterprise provider audits and rate-setting unit for Iowa within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement shall be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions which are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services.

These rules are intended to implement Iowa Code section 249A.4.

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be either:

a. Eligible for one of the coverage groups listed in 441—75.1(249A); or

b. Eligible under the IowaCare program pursuant to 441—Chapter 92.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.*

a. While on inpatient status, a person eligible under a coverage group listed in 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

b. While on inpatient status, a person eligible under the IowaCare program is entitled to the services listed at 441—92.8(249A,81GA,ch167).

441—85.9 to **85.20** Reserved.

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

441—85.21(249A) Conditions for participation. Psychiatric medical institutions for children shall be issued a license by the department of inspections and appeals under Iowa Code chapter 135H and shall hold either a license from the department of human services under Iowa Code section 237.3, subsection 2, paragraph *"a,"* subparagraph (3) or, for facilities which provide substance abuse treatment, a license from the department of public health under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

441—85.22(249A) Eligibility of persons under the age of 21.

85.22(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.22(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.22(3) *Certification for need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.22(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in rule 441—75.1(249A), except medically needy.

441—85.23(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.24(249A) Responsibilities of facilities.

85.24(1) *Medical record requirements.* The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.24(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.24(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. Individual plan of care. An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care, or involved in consulting with or supervising those professionals involved in the direct provision of care.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.25(249A) Reimbursement to psychiatric medical institutions for children.

85.25(1) *Computation of inpatient rate.* Facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

a. Rates for new facilities are based on historical costs submitted on Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts, if the institution is established and has the historical data. If the institution is newly established, the rate shall be based on a proposed budget submitted on

Form 470-0664. A Form 470-0664 with actual cost data shall be submitted after at least six months of participation in the program for a new rate adjustment.

b. After the initial cost report period, the institution shall submit Form 470-0664 annually within three months of the close of the facility's fiscal year. Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

c. For services rendered July 1, 2010, through June 30, 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1)*"a"* and *"b,"* subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

85.25(2) *Reserve bed payments.*

a. Reserve bed day payment for days a resident of a psychiatric medical institution for children is absent from the facility for hospitalization in an acute care general hospital is paid in accordance with the following policies:

(1) The intent of the department and the facility shall be for the resident to return to the facility after the hospitalization.

(2) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the hospitalization.

(3) Payment for reserve bed days shall be canceled and payment returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous hospital stay.

b. Reserve bed days for visitation shall be made for days a resident is absent from a psychiatric medical institution for children at the time of a nightly census for the purpose of visitation when the absence is in accordance with the following policies:

(1) The visits are consistent with the child's case permanency plan and the facility's individual case plan.

(2) The intent of the department and the facility shall be for the child to return to the facility after the visitation.

(3) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the visit.

(4) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment for reserve bed days shall be canceled effective the day after a decision not to return the child is made by the court or, in a voluntary placement, by the parent.

(6) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

c. Reserve bed payment shall be made for days a resident is absent from a psychiatric medical institution for children at the time of the nightly census for reasons such as detention, shelter care, or running away when the absence is in accordance with the following policies:

(1) The intent of the department and the psychiatric medical institution for children shall be for the child to return to the facility after the absence.

(2) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the

child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(3) Payment for reserve bed days shall be canceled effective the day after a decision is made not to return the child by the court or, in a voluntary placement, by the parent.

(4) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

(5) Reserve bed day payment is not available until the child has been physically admitted to the psychiatric medical institution.

(6) The psychiatric medical institution shall notify the department social worker within 24 hours after the child is out of the facility for running away or other unplanned reasons.

85.25(3) *Day treatment rates.* Outpatient day treatment services are paid on a fixed fee basis.

[**ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10]

441—85.26(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections and appeals for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

EXCEPTION: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

441—85.27 to **85.40** Reserved.

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

441—85.41(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to department of inspections and appeals rules 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to department of inspections and appeals rule 481—51.33(135B). A distinct part of a general hospital may be considered a psychiatric institution. In addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall be 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).

441—85.42(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.

441—85.43(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A), except for medically needy.

441—85.44(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.45(249A) Responsibilities of nursing facility.

85.45(1) *Medical record requirements.* The facility shall obtain a PRO determination that the person requires psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.45(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

441—85.46(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.

441—85.47(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month shall receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

[Prior to 7/1/83, Social Services [770] Ch 108]
[Prior to 2/11/87, Human Services [498]]

PREAMBLE

This chapter establishes licensing procedures for all child-placing agencies authorized by Iowa Code chapter 238. Included in this chapter are rules relating to: the licensing process; administration and organization; foster care services; adoption services; and supervised apartment living services.

441—108.1(238) Definitions.

"Administrator" means the person who is designated to have day-to-day responsibility for the administration of a child-placing agency, and who ensures that the mission of the agency and laws relating to the welfare and protection of children are carried out.

"Adoptive applicant" means the person who has requested approval for placement of a child for adoption from a licensed child-placing agency.

"Adoptive family" means an approved person or persons who have a child placed in their home for the purpose of adoption and are being supervised by the agency or who have a child in their home who has been legally adopted and is entitled to the same benefits as a child born to the parents.

"Approved living arrangement" means that the living situation shall be located so as to provide reasonably convenient access to schools, places of employment, or services required by the youth, comply with applicable state and local zoning, fire, and sanitary regulations, and be reasonably priced so as to fit within the youth's budget.

"Caseworker" means the person who works directly with children, their families, and other relevant individuals and who has primary responsibility for the development, implementation, and review of the agency's service plans for the child and parents; or who completes foster care or adoptive family home studies or supervises foster family or adoptive placements; or who supervises children placed in approved supervised apartment living arrangements.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Child-placing agency" means an agency organized within the state of Iowa for the purpose of receiving minor children for placement, supervision, or both in private family homes for foster care; or for adoption; or the placement, supervision, or both of children who are 16 years of age and older living in approved supervised apartment living placements.

"Department" means the department of human services.

"Parent" means custodial and noncustodial parent.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Sibling" means two or more persons having at least one common parent.

"Supervised apartment living placement" means the placement of a child who is at least 16 years of age in an approved living arrangement which provides an environment in which the child can experience living in the community with minimum supervision.

"Volunteer" means any nonpaid person who donates time to an agency, either in working with an individual or groups of clients. A volunteer may also be a student intern.

441—108.2(238) Licensing procedure.

108.2(1) *Right to apply.* Any person or agency has the right to make application for a child-placing license. When applying for a child-placing license, the applicant shall indicate the services for which licensure is being requested.

108.2(2) *Application.* An agency or person applying for a license shall complete Form 470-0723, Application for License or Certificate of Approval. The application shall be completed and signed by the administrator or the appropriate officer and submitted to the department.

a. The applicant shall report withdrawal of an application to the department within 30 days of the withdrawal decision.

b. Each application shall be evaluated by the department to ensure that all requirements are met.

c. The applicant shall provide requested reports and information relevant to the licensing determination to the department.

108.2(3) *Applications for renewal.* Applications for renewal shall be made to the department at least 30 but no more than 90 days before expiration of the license.

108.2(4) *Notification.* Agencies shall be notified of approval or denial within 90 days of application or reapplication.

108.2(5) *Certificate of license.* The department shall issue or renew Form 470-3623, Certificate of License, every three years, without cost, to any child-placing agency which meets the minimum requirements applicable to child-placing agencies as defined by Iowa Code chapter 238 and this chapter. The license shall be posted in a conspicuous place on the licensed premises.

108.2(6) *Provisional license.* A provisional license may be issued to an agency which does not meet all licensing requirements when the failure to meet all licensing requirements does not pose a danger to the health, safety, or well-being of the children being served. It is issued until the agency meets all requirements, up to a maximum time period of one year. A provisional license is issued when the applicant has signed a written statement which includes the following:

a. The deficiencies necessitating the provisional license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(7) *Suspension of a license.* The suspension of a child-placing license prohibits the agency from engaging in any child-placing activities during the period of the suspension. The department shall suspend a license when the agency's failure to meet the requirements poses a danger to the health, safety, or well-being of the children being served. The suspension of a license shall not extend beyond 12 months, and the existence of the condition requiring suspension shall be corrected within a year and documented in the agency's record.

The agency shall submit a written statement for approval by the department. The statement shall include the following:

a. The deficiencies necessitating the suspended license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(8) *Completed corrective action.* When the corrective action plan is completed on or before the date specified on the provisional license or notice of suspension, a full license shall be issued for the remainder of the licensing period.

108.2(9) *Denial or revocation of a license.* The department shall deny an application or reapplication for a license or revoke a license when the applicant fails to meet the licensing requirements or when any of the following conditions exist:

a. The agency is operating without due regard to the health, safety, and well-being of the children being served.

b. A provisional license is not approved.

c. The recipient of a provisional license fails to complete the corrective action plan within the time allowed.

d. An agency with a suspended license fails to complete the corrective action plan on time and a provisional license is not appropriate.

e. The agency misuses public funds.

f. The agency refuses to cooperate with child protective investigations involving children placed by the agency.

g. The agency continuously and significantly violates licensing requirements.

108.2(10) *Method and content of notice.* The notice of denial, revocation, or suspension shall be sent by restricted certified mail and shall include the following:

a. A specific description of the condition requiring the suspension, denial or revocation.

b. The specific laws or rules violated.

c. The effective date of denial, revocation or suspension.

108.2(11) *Right to appeal.* Any agency which disagrees with the department's licensing decision may appeal to the department. The appeal shall be filed within 30 days of receipt of the licensing decision.

441—108.3(238) Administration and organization.

108.3(1) *Statement of purpose.* The agency shall have a written statement of its child-placing philosophy, purpose, and program. The statement shall contain a description of services and methods for service delivery and a description of the persons for whom the services will be provided. The statement shall be available to the public.

108.3(2) *Governing board.* The agency shall have a governing board which, together with the executive, shall be responsible for making policy and for financing and general management of the agency. The governing board may be either the board of directors or the owners of the agency. If the governing board is a board of directors, the following rules shall apply:

a. The agency shall provide for continuity of board membership.

b. The board shall meet regularly for the purpose of ensuring the proper operation of the agency and fulfilling its responsibilities.

c. The minutes of each meeting of the board shall be kept and made a part of the permanent record of the agency.

108.3(3) *Annual report.* A child-placing agency shall require the administrator to submit a written annual report of the agency's activities. The report shall include fiscal and statistical sections indicating receipts and disbursements, number of clients served, and programs. The annual report shall be available to the department.

108.3(4) *Table of organization.* A table of organization, including the identification of lines of responsibility and authority for policy making and service to clients, shall be available to agency staff and to the department.

108.3(5) *Finances.* The licensee shall:

a. Annually develop and implement a plan of financing which is necessary for the operation of the agency in carrying out its programs, ensuring proper care for children, and meeting requirements for licensing.

b. Annually provide either an audit or a detailed financial statement prepared by an independent fiscal agency that provides a review of receipts and disbursements and a statement of fund balances.

c. Retain fiscal records for five years.

108.3(6) *Employment of administrator.* The agency shall employ a qualified administrator and shall delegate to the administrator the responsibility for the administration of the agency. The administrator shall ensure that the mission of the agency and laws relating to the welfare and protection of children are carried out.

108.3(7) *Office space, equipment and supplies.* The agency shall provide and maintain sufficient office space, equipment, and supplies to ensure delivery of services.

441—108.4(238) Staff qualifications. An agency employee or volunteer shall be a person of good character, emotional stability, and have necessary ability, experience, and education to perform the duties assigned. An employee or volunteer shall not have a criminal record or founded child abuse report, unless the department has evaluated the crime or founded report and concluded that the crime or report does not merit prohibition of employment or licensure.

108.4(1) *Contracted employees.* A child-placing agency which contracts for services shall ensure that contracted employees meet the same qualifications, training, and evaluation requirements as those of workers in employed positions. A child-placing agency is responsible for the services provided by contracted providers as well as volunteers and agency employees.

108.4(2) *Qualifications of administrator.* An agency administrator shall possess one of the following:

a. A master's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and two years of experience in a public or private social services agency.

b. A bachelor's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and four years of experience in a public or private social services agency.

108.4(3) *Caseworker qualifications.* Therapy and counseling services, psychosocial evaluation and assessment and care plan development shall be provided by staff who meet one of the following minimum education and experience criteria:

a. Graduation from an accredited four-year college or university and the equivalent of three years of full-time experience in social work or experience in the delivery of human services in a public or private agency. In addition, these individuals shall have been employed by the agency prior to September 1, 1993. Persons meeting this criterion will not be qualified to provide therapy and counseling if they change place of employment.

b. Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work from a program accredited by the council on social work education.

c. Graduation from an accredited four-year college or university with a bachelor's degree in a human service field related to social work and the equivalent of two years of full-time experience in social work or experience in the delivery of human services in a public or private agency.

d. Graduation from an accredited four-year college or university with a master's degree in social work or related human service field.

e. Any equivalent combination of graduate education in the social or behavioral sciences from an accredited four-year college or university and qualifying experience up to a maximum of 30 semester hours for one year of the required experience.

108.4(4) *Person filling more than one position.* A person functioning in more than one position specified by these rules shall meet the requirements for each of the positions the person fills.

441—108.5(238) Staffing requirements.

108.5(1) *Number of staff.* The agency shall employ a sufficient number of competent staff to perform duties as required by licensing rules for those programs operated by the agency. This shall include the following:

a. Administration of services offered by the agency.

b. Selection and appointment of qualified staff.

c. Provision for staff training.

108.5(2) *Staffing caseload.* The agency shall develop a written policy regarding a staffing ratio based on the workload necessary to provide services in accordance with the agency's program statements. The staffing ratio shall take into consideration all of the following:

a. Qualifications of the caseworkers.

b. Types of children served and their special needs.

c. Types and intensity of services to be provided.

d. Distances involved in provision of services.

e. Other functions or responsibilities of the caseworkers.

441—108.6(238) Personnel administration.

108.6(1) *Personnel policies.* An agency shall develop personnel policies in writing that identify responsibilities of the organization and staff. The policies shall specify hours of work, grievance procedures, sick leave, vacation and all other benefits. A copy of the policies shall be made available to the employee at time of hire.

108.6(2) *Job description and evaluation.* There shall be a written job description for each employee, volunteer, and contracted position identifying duties, qualifications, education, training requirements,

and lines of authority. A copy shall be made available to the employees, volunteers, and contracted workers. There shall be a written evaluation of an employee's or contracted worker's performance within six months of being hired or contracted, and annually thereafter.

108.6(3) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted casework staff. The 24 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics, and 2 hours of training related to the identification and reporting of child abuse for all employed or contracted casework staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed or contracted casework staff. The 12 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics and child abuse training every five years in accordance with Iowa Code section 232.69.

The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

108.6(4) *Volunteers.* An agency which utilizes volunteer or student intern staff to work directly with a particular child or group of children shall have a written plan for using these volunteers. This plan shall be given to all volunteer staff and shall indicate that all volunteers are:

a. To be supervised directly by a paid staff member.

b. To be trained and oriented in the philosophy of the agency, the needs of the clients being served, and the methods of meeting these needs.

c. To be subject to the character and reference disclosure and checks required of employed and contracted applicants and employees.

d. To be subject to the same confidentiality rules as paid or contracted staff.

e. To assist and supplement paid staff only, and not replace them.

108.6(5) *Personnel records.* A confidential personnel record shall be maintained for each employee, contracted agent, and volunteer. The record shall contain all of the following information:

a. Name and address.

b. Record of training sessions attended, including dates and content of training.

c. Record of criminal convictions and the department's evaluation of same.

d. Record of founded child abuse reports and the department's evaluation of same.

441—108.7(238) Foster care services.

108.7(1) *Program statement.* An agency authorized to place children in foster care shall have a current written program statement. This statement shall be made available to all agency foster parents, foster children, their parents, referring agencies, and all persons making formal inquiry regarding foster care. The program statement shall include all of the following:

a. Types of foster care provided.

b. Types of children accepted for foster care.

c. Types of services provided to the children, their families, and their foster families.

d. Fees and application costs, if any.

e. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for foster care.

108.7(2) *Agency's authorization to place.* The agency shall obtain a signed placement agreement from the child's custodial parent or legal custodian within 48 hours of placement.

108.7(3) *Preplacement documentation.* Except for emergency placements, a child shall be placed in the agency's foster care program only after the agency determines that its foster care program is an appropriate resource.

108.7(4) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not in the best interest of the child, the reasons shall be documented in the child's record.

108.7(5) *Consideration of racial and cultural identity.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.7(6) *Placement preparation.* An agency shall document the preparation for each child placed in foster care. Preparation shall be appropriate to the child's age, individual needs, the circumstances requiring placement, and the special problems presented. Preparation activities shall, when possible, include:

a. Face-to-face visits.

b. A description provided to the child of the foster family.

c. A description of the child's strengths and needs and safety-related information provided to the foster family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

d. Any other activities deemed significant.

108.7(7) *Initial placement outline.* If a placement outline is not in the child's case permanency plan, a brief outline documenting all of the following shall be entered in the child's case record within five working days after placement:

a. Name, birthdate, sex, race, and other significant identifying information.

b. Date of placement.

c. Name and address of parents or legal guardian.

d. Names and whereabouts of siblings.

e. Religious preference.

f. Immediate and significant health needs including the child's physical and emotional state at the time of placement.

g. The circumstances leading to the need for foster care.

h. Known previous out-of-home placements.

i. The immediate needs of the child and parents and services to be provided to meet these needs.

j. The name, address, and telephone number of the referring agent or worker.

108.7(8) *Education.* Within ten school days of placement, provisions shall be made by the agency for enrollment of each child of school age into a school program.

108.7(9) *Clothing.* An agency shall make provisions for adequate and individualized clothing for each child admitted into foster care.

108.7(10) *Monthly visit.* Each child in care shall be personally visited by the assigned caseworker at least once a month.

108.7(11) *Parent and child contact.* Provisions for contact between parents and children shall be made except where the parental rights have been terminated or where the court has determined that visits or contact are detrimental to the child.

a. If the mother is breastfeeding the child:

(1) An assessment shall be made whether continuation of breastfeeding is in the best interest of the child; and

(2) A plan shall be developed to support the mother's breastfeeding efforts, if appropriate.

b. The parents and child shall be informed of the contact plan in a manner consistent with their capacity to understand.

108.7(12) *Health and dental program.* An agency shall provide for a complete health and dental program for each child. An agency shall have a written procedure for handling medical emergencies on a 24-hour basis. A copy of the procedure shall be given to each foster home.

a. The agency shall obtain written authorization from the parent or legal guardian to provide medical, psychiatric, dental, anesthesia, immunization, substance abuse evaluation, and emergency

surgical treatment. Only the parent or legal guardian shall consent to nonemergency surgery, unless ordered by court. If the child's parent prohibits medical examination, immunization, or treatment based on religious grounds, the agency shall obtain a signed statement from the parent that specifies the prohibitions. In potentially life-threatening situations, the agency shall refer the child's care to appropriate medical and legal authorities.

b. A child shall have a physical examination at least annually. This shall be performed by a licensed physician, physician's assistant or licensed nurse practitioner.

c. A child shall have current immunizations as required by the department of public health. If documentation of prior immunization is unavailable, immunizations shall begin within 30 days of placement, unless contraindicated and unless a statement from a physician to that effect is included in the child's medical record. A statement from physician, referring agency, parent, or guardian indicating immunizations are current is sufficient documentation of immunizations.

d. An agency shall provide for dental examinations and treatment; the initial referral at 12 months of age, the next at 24 months of age, then every 6 months.

e. A health record shall be maintained for each child and shall include all of the following:

(1) Authorization for medical care.

(2) A medical history and copies of required physical examinations.

(3) A record of medical and dental care, treatment and prescribed medication, immunizations, accidents requiring medical treatment, and hospitalizations. At the time of discharge from agency foster care, a summary of this record shall be provided to the legal custodian. Information about drug evaluation or treatment, venereal disease tests, HIV tests, and pregnancy tests shall be excluded.

108.7(13) *Service plan development and review.* The provider shall develop and revise service plans for each child in placement. An initial service plan shall be developed within 30 calendar days of placement in foster care. The provider shall identify qualified persons to monitor the services identified in the service plan to ensure that the plan continues to be necessary, appropriate, and addresses the permanency goal. Service plans shall be developed and reviewed as follows:

a. The service plan shall be developed and revised in collaboration with the referral worker, child, family, and the foster parents unless the service plan contains documentation for the treatment rationale for the lack of involvement of one of these parties. The provider shall document the dates and content of the collaboration on the initial and revised service plans. The provider shall provide a copy of the initial and revised service plans to the child's parent and the referring agency, unless otherwise ordered by the court. The initial and revised service plan shall identify the following:

(1) Strengths and needs of the child and parents.

(2) Goals, which are statements of outcomes to be achieved in meeting the needs of the child including the child's permanency needs.

(3) Objectives, which are specific, measurable and time-limited statements of indicators, levels of competence, or accomplishments which are necessary for progress toward each goal.

(4) Specific treatment service activities to be provided to achieve the objectives.

(5) Designation of the persons responsible for providing the services.

(6) Date of initiation and service plan development.

(7) Anticipated duration of services.

b. All service plans shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services or when the needs of the child or the services necessary for the parents to meet the needs of the child have changed and these changes significantly affect goals, objectives and service activities. The review shall determine if the services continue to be necessary, appropriate and consistent with the child's permanency goal. The reviewer shall revise the service plan to reflect the services that are necessary, appropriate, and consistent with the child's permanency goal.

108.7(14) *Information for foster parents.* At the time of placement, an agency shall provide foster parents with all of the following if known:

a. Name of the child, agency caseworker, and referring agency.

b. Information about the child's known behavioral characteristics including safety-related information, needs, and plans for the child and family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court, or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. Written consent to obtain routine, nonsurgical medical care and to authorize emergency medical and surgical treatment, anesthesia, and immunizations for each child placed in the foster home.

d. A copy of the child's current physical examination and medical history when completed.

As this information becomes available to the agency, foster parents shall be informed immediately.

108.7(15) *Religious policy.* The agency shall have a written policy on religious participation and training for foster children. The agency shall provide the policy to parents and foster parents and shall ensure that the policy is adhered to in each foster home.

108.7(16) *Mail.* There shall be a written policy which ensures that foster children are permitted to send and receive mail, unless documented that this practice is contraindicated.

108.7(17) *Allowance policy.* An agency shall have a written policy addressing payment of and accounting for personal allowances for foster children.

108.7(18) *Reporting hospitalization or death of child.* Any serious injury or illness requiring hospitalization of a child in care shall be reported to the parent and the responsible agency as soon as possible. Efforts to notify parents and responsible agency staff shall be documented in the child's record. The death of a child shall be reported immediately to the parent or next of kin and to the referring agency.

108.7(19) *Foster care records.* The agency shall maintain confidential individual records for each child placed in a foster home. The record shall include:

a. The initial placement outline. (Refer to subrule 108.7(7).)

b. All legal documents pertaining to the child.

c. The child's health record, including psychological and psychiatric reports.

d. The summary narrative which reflects the dates and content of the caseworker's contact regarding the child.

e. Educational records and reports.

f. All service plans developed by the agency.

g. Case permanency plans developed by the referring agency.

h. A record of foster placements made by the agency including foster parents' names and addresses and dates of placements.

108.7(20) *Termination of foster care.* When a foster care placement is terminated, all of the following information shall be documented in the child's record within 30 days:

a. Reason for termination.

b. Current location of the child, unless the child was placed for adoption. In that case the record shall state only that the child was placed for adoption and shall not disclose the identity of the adoptive family unless the adoptive family agrees to disclosure of identity prior to finalizing of adoption.

c. Steps remaining to achieve permanency plan goal.

d. Provisions for follow-up, if any.

e. For unplanned terminations, a summary explaining the circumstances.

441—108.8(238) Foster home studies. The agency shall provide information to prospective foster parents about foster care, agency policies, licensing requirements for foster care, the children needing foster care, the licensing process and the reimbursement rates.

108.8(1) *Licensing procedures.*

a. Availability of applications. The agency may provide Form 470-0689, Foster Family Home License Application, to anyone requesting to be licensed.

b. Licensing study. The agency may complete a licensing study of the family.

c. New applications. If the child-placing agency decides to complete the initial licensing study, the agency shall submit to the department all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include a narrative evaluation of the foster family home which reflects a thorough study of each foster family. The narrative shall document at least two face-to-face interviews with the prospective foster family and at least one face-to-face interview with each member of the household before the placement of a child. At least one interview shall take place in the applicant's home. The narrative summary of the family study shall assess all of the following:

(1) Motivation for foster care.

(2) Family's and extended family's attitude toward accepting foster children.

(3) Family's attitude toward foster children's parents.

(4) Emotional stability, physical health, and compatibility of foster parents, and ways they cope with change and stress.

(5) Adjustment of own children, if any.

(6) Assessment of the child-caring skills, including disciplinary techniques used.

(7) Strengths and weaknesses of each member of the household.

(8) Types of children desired.

(9) Type of children, if any, for whom placement with the family would be appropriate.

(10) Recommendation as to the number, age, sex, characteristics, and special needs of children best served by this family.

(11) Assessment of the need for training and a plan for providing the needed training.

(12) Any other pertinent information that might assist the agency in making the licensing recommendation.

(13) Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B, for this purpose. Each person subject to record checks shall also be fingerprinted for a national criminal history check. The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting. Any criminal or abuse records discovered shall be evaluated according to the procedures in rule 441—113.13(237).

(14) Health of foster parents and impact of medical conditions on their ability to foster a child.

(15) Income information.

(16) Documentation that at least three references have been received and the responses reviewed.

108.8(2) *Licensing decision.* The department shall make the licensing decision and notify the applicant and the child-placing agency within 30 days of the licensing decision. In no case shall a child be placed in a foster home before licensing approval.

a. A full license shall be issued to foster families meeting all necessary criteria for a full licensure.

b. A provisional license may be issued for up to one year if the foster family fails to meet all requirements for licensure. When an agency recommends, because of rule violation, that a foster home receive a provisional license at the time the license is issued or renewed, the agency shall document the violation in the foster home file, and shall send the following to the department:

(1) A copy of the assessment of the rule violation and recommendation.

(2) A copy of the foster home's plan to achieve rule compliance within stipulated time frames.

c. When an agency recommends that a foster home license be denied or revoked, the agency shall send the following documents to the department:

(1) A copy of the assessment of rule compliance and the foster family's reaction to the assessment.

(2) The agency's recommendation and supporting rationale.

(3) Other appropriate documents supporting the findings.

108.8(3) *Reapplications.* At least 30 days before the expiration of the license, the agency shall submit all documents and information required by 441—Chapter 113 pertaining to the licensing and

regulation of foster family homes. This shall include an update of the narrative noting any changes that may have occurred in the foster family's living arrangement or life style and any other pertinent information that might assist in making the licensing decision, including an assessment of the foster family's ability to provide foster care.

108.8(4) *Unannounced visits.* The agency shall conduct at least one annual unannounced visit to each licensed foster family home the agency inspects to meet the requirements of Iowa Code section 237.7.

108.8(5) *Complaints.* When an agency receives a complaint which may indicate possible violation of the foster care licensing rules, the agency shall, within five working days of receiving the complaint, either conduct an investigation to assess compliance with applicable rules or refer the complaint to the department for investigation. If the agency conducts the investigation, the agency shall submit a written report of the investigation to the department within ten working days of receiving the complaint with a statement of rule violation and a recommendation regarding the license of the foster family home. The written report shall be filed in the foster parents' file.

108.8(6) *Foster family training.* The agency shall ensure that each foster home recommended for foster family license has complied with the training requirements in 441—113.8(237).

Within six months of licensure and every five years thereafter, each foster parent shall obtain mandatory reporter training relating to identification and reporting of child abuse.

108.8(7) *Placement agreement.* When a child is placed with a foster family, the agency shall have a signed agreement with each foster family home including the expectations and responsibilities of both the agency and the foster family, the services to be provided, and the financial arrangements for children placed in the home.

108.8(8) *Foster family home records.* The agency shall keep separate records for each foster family home. The agency shall begin the record at the time of application. Foster family home records shall contain:

a. The application.

b. Family assessment.

c. Most recent medical reports on foster family members.

d. Summary of dates and content of worker's contacts relating to licensing or relicensing.

e. Reference letters.

f. Annual assessment of strengths and weaknesses of the foster family relative to the care of individual children placed with them.

441—108.9(238) Adoption services.

108.9(1) *Program statement.* An agency licensed to place children for adoption shall have a current written program statement which shall include all of the following:

a. Types of children to be placed.

b. Eligibility requirements for adoptive families.

c. Services provided during the adoption process.

d. Services to the birth parents upon relinquishment.

e. Postadoption services to adoptive families, if offered.

f. Fees and application costs.

g. A statement that payment of fees does not ensure adoption approval.

h. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for adoption, or other adverse decisions.

The program statement shall be made available to referring agencies and to all persons making formal inquiry regarding adoption.

108.9(2) *Services to birth families.* An agency which offers services to birth parents who are considering relinquishing a child for adoption shall provide a minimum of three hours of counseling, or any additional hours of counseling necessary to assist the parents in making an informed decision regarding their child's adoption, consistent with the child's best interest. The counseling of the birth

parents shall begin when the birth parents begin the intake process. This shall be documented in the service plan format.

a. Intake process. When an agency agrees to provide services to the birth parents, intake interviews shall be conducted, including provision of information to the birth parents regarding the adoption process and their rights and role.

b. Background information. A collection of information about the birth parents and the child shall include, but need not be limited to:

(1) The child's legal status, or due date if unborn.

(2) The child's physical description, medical and mental health history, developmental information, and other pertinent information necessary for a child study.

(3) Identification of any specific needs of the child and the type of family to be considered for adoptive placement.

(4) The birth parents' strengths and needs.

(5) The involvement of the birth parents and significant others in the child's care.

(6) The birth family's physical description, medical and mental health history, educational level, any problematic areas including substance and alcohol abuse.

(7) An affidavit signed by the birth parents regarding wishes for the court to reveal, or not reveal, their names to the child pursuant to Iowa Code chapter 600.

(8) Any additional information the birth family wishes to have included in the child's adoption record.

108.9(3) *Preparation of child for adoptive placement.* Preparing a child, especially an older child, includes activities designed to enable a child to make a transition to an adoptive placement. The activities shall include, but are not limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Preparation of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support group to assist the child in the transition and integration into the adoptive family.

108.9(4) *Services to adoptive applicants.*

a. Application process. Before proceeding with an adoptive home study, the agency shall have received an application for adoption from the person or persons wishing to adopt a child. The application form shall include information about the applicant's intent to become an adoptive parent, and the basic data about the applicant's family, home, financial status, health, and references.

b. Explanation of the adoption process. The agency shall provide the applicant an explanation of the entire adoption process, including the legal procedures, the agency policies and procedures regarding placement of children, and the children available for adoption.

c. Adoptive home study. The home study consists of a family assessment which shall include at least two face-to-face interviews with the applicant and at least one face-to-face interview with each member of the household. At least one interview shall take place in the applicant's home. The assessment shall include, but need not be limited to, the following:

(1) Motivation for adoption and whether the family has biological, adopted or foster children.

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child.

(3) The attitude toward adoption of the significant other people involved with the family.

(4) Emotional stability; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation and loss.

(6) Medical, mental, or emotional conditions which may affect the applicant's ability to parent a child.

(7) Ability to provide for the child's physical and emotional needs and respect the child's cultural and religious identity.

(8) Adjustment of biological and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.

(9) Capacity to give and receive affection.

(10) Statements from at least three references provided by the family and other unsolicited references that the agency may wish to contact.

(11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(12) Income information, ability to provide for a child, and a statement as to the need for adoption subsidy for a special needs child, or children.

(13) Disciplinary practices that will be used.

(14) History of abuse by family members and treatment.

(15) Assessment of, commitment to, and capacity to maintain other significant relationships.

(16) Substance use or abuse by members of the family and treatment.

(17) Recommendations for type of child, number, age, sex, characteristics, and special needs of children best parented by this family.

d. Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B, for this purpose.

If there is a record of founded child abuse or a criminal conviction for the applicant, or anyone living in the home of the applicant, the licensed child-placing agency shall not approve the applicant as an adoptive family, unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

EXCEPTION: The person making the investigation shall not approve a prospective applicant and the department shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."* The person making the investigation shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in another state that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

The evaluation shall consider the nature and seriousness of the abuse or crime, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person. The person with the criminal conviction or founded child abuse report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of approval for adoption.

(1) If the applicant, or anyone living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the licensed child-placing agency. The licensed child-placing agency shall notify the applicant of the results of the evaluation.

(2) If the applicant, or anyone living in the home of the applicant, has a founded child abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the licensed child-placing agency shall initially conduct the evaluation.

1. If the licensed child-placing agency determines that the abuse or crime does warrant prohibition of approval, the licensed child-placing agency shall notify the applicant of the results of the evaluation.

2. If the child-placing agency believes that the applicant should be approved despite the abuse or criminal conviction, the agency shall provide copies of Form 470-2310, Record Check Evaluation,

and Form 470-2386, Record Check Decision, to the Department of Human Services, Administrator, Division of Behavioral, Developmental, and Protective Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Within 30 days, the administrator shall determine whether the abuse or crime merits prohibition of approval and shall notify the child-placing agency in writing of that decision.

The licensed child-placing agency shall also notify the family in writing no later than 30 days after completion of the home study of the agency's decision regarding approval for placement of a child. If the family is denied, the agency shall state the reasons for denial. The agency worker and supervisor shall date and sign the adoptive home study. The agency shall provide a copy of the home study to the family. An agency shall not place a child in an adoptive home before the family is approved, or before a placement agreement is signed by the family and the agency.

e. A home study update is required if the adoptive home study was written more than one year previously, in accordance with Iowa Code section 600.8. The preplacement assessment update shall be conducted by completing the following:

(1) The child abuse and criminal record checks shall be repeated and any abuses or convictions of crimes since the last record check shall be evaluated using the same process.

(2) A minimum of one home visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) A written report of the assessment and updated adoptive home study shall be completed, dated, signed by the worker and the supervisor, and provided to the adoptive family.

108.9(5) *Services to adoptive families.*

a. Preparation of the family includes activities designed to prepare the adoptive family for the placement of a particular child. These activities shall assist the adoptive family in expanding its knowledge and understanding of the child and enhance the family's readiness to accept the child into their family and encourage their commitment. The activities shall include, but not be limited to:

(1) Providing background information on the child and the birth family, including a child study that includes past experiences such as foster and adoptive placements.

(2) Providing information regarding the special needs and characteristics of the child.

(3) Providing information regarding an older child's anticipated behavior.

(4) Discussing the impact that adding a new member to their family may have on all current family members.

(5) Discussing the issues of separation, loss, grief, anger, and guilt that adoptive children experience at various developmental stages.

(6) Providing the family with community resources that are available, such as support groups.

b. Preplacement services include the preplacement visits of the child and approved family and any activities necessary to plan, conduct, and assess these transitional visits before the placement of the child in the adoptive family's home for the purpose of adoption.

c. Postplacement services include postplacement supervision, support, crisis intervention, and required reports to the court. The postplacement services are provided from the time the child is placed with an approved adoptive family until finalization of the adoption occurs.

A minimum of three face-to-face postplacement visits are required, or if the family is experiencing problems, as many as are necessary to support the placement. At least two of the visits shall be in the adoptive home. At a minimum the first visit shall be completed within 30 days after placement; the second visit within 90 days after placement; and the final visit before granting consent to adopt.

Observations made during the home visits shall be recorded in the family's adoption file and used by the agency in making written recommendations to the court regarding finalization of the adoption.

Postplacement supervision should focus on the following:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the placement.

(3) Social, emotional adjustment of the child and school adjustment of a child who is attending a school.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes that have occurred in the family since the placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

d. Postadoption services. The agency shall provide postadoption services to adoptive parents and adoptees, or shall refer adoptive parents and adoptees to other community resources for the services.

108.9(6) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not possible, or is not in the best interest of the children, the reasons shall be documented in the record. Efforts shall be made to provide continued contact between siblings after finalized adoptions if the siblings are not placed together.

108.9(7) *Racial and cultural background.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.9(8) *Religious policy.* There shall be a written policy on religious participation for prospective placing parents, adoptive parents, and adoptees. The policy shall be made available to referral sources as well.

108.9(9) *Adoption records.* The agency shall keep separate records for each prospective, approved, or active adoptive family. Contents of these records shall be as follows:

a. The application.

b. The adoptive home study.

c. Current medical records.

d. All references.

e. All legal documents pertaining to the adoption.

f. Birth family information and background report, including physical descriptions, medical and mental health history, educational level, developmental history, problem areas such as substance or alcohol abuse.

g. Summary narrative on the placement decision and the preplacement and postplacement contacts with the adoptive family and child.

h. Information pertaining to the child including, but not limited to: physical, medical, and mental health; problem areas, including verification of the child's special needs; and whether or not a referral was made to the department for adoption subsidy.

i. In the event a family is not approved for placement of a child, the narrative shall clearly indicate the reason.

j. In the event a family is approved, but no child is placed with them, the narrative shall clearly indicate the reason.

108.9(10) *Right to appeal.* An adoptive applicant or an adoptive family may appeal an adverse decision made by a licensed agency. The appeal shall be filed with the department within 30 days of the notice of decision to the applicant or family by the licensed agency.

108.9(11) *Disposition of records.* When an adoption has occurred, the agency must maintain all records regarding the child, the birth family, and the adoptive family or families, forever. Any subsequent information received following the adoption finalization shall be placed in the adoption record. If the agency closes, all adoption records shall be forwarded to the department.

441—108.10(238) Supervised apartment living placement services. An agency seeking to obtain a child-placing license which authorizes the agency to place or supervise children in supervised apartment living placements shall meet the standards in rules 108.2(238) to 108.6(238).

108.10(1) *Program statement.* An agency authorized to place or supervise children in supervised apartment living placements shall have a current written program statement which includes all of the following:

a. A description of the types of living arrangements approved by the agency.

b. The eligibility requirements for the children who may be placed in a supervised apartment living placement.

c. The means of financial support for the children.

d. The expectations the agency has for children while placed in a supervised apartment living placement.

e. Services provided to the children.

f. Provisions for emergency medical care.

This program statement shall be provided to all children placed in supervised apartment living.

108.10(2) *Basis for placement.* Before placing a child in supervised apartment living, an agency shall document all of the following:

a. The child is at least 16 years of age.

b. An initial assessment has been made that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

c. The child has the capacity to function outside the structure of a foster family or group care setting.

d. The selection of a supervised apartment living placement is the most appropriate placement for the child.

e. The child shall be involved in school or other educational or vocational program, work, or a combination thereof on a full-time basis, as indicated in the child's individual care plan.

f. The child has entered into a mutually agreed-upon written contract with the agency which specifies the responsibilities of the agency and the child. This contract shall be reviewed quarterly.

g. It has been determined, through a visit to the living arrangement, that the minimum standards for approval have been met.

108.10(3) *Services provided.* The following services are required:

a. Ongoing assessment that identifies child's strengths and needs as these pertain to the child's ability to live independently.

b. The development of an individual service plan within 30 days of placement. The service plan shall be developed in consultation with the child and referring agent. The individual service plan shall include projection of the expected length of stay in supervised apartment living and shall address the activities necessary to achieve independence and the services needed to be provided to the child. The individual service plan shall be updated quarterly.

c. Supervision to assist the youth in developing the needed structure to live in this setting and in locating and using other needed services. Supervision may include guidance, oversight, and behavior monitoring.

(1) If the youth is under age 18, supervision shall include a minimum of weekly face-to-face contacts.

(2) For youth aged 18 or older, supervision shall include a minimum of biweekly face-to-face contacts.

d. Personal observation by the agency worker that the living situation provides safe and suitable social, emotional, and physical care.

e. Maintenance of a means by which the youth can contact agency personnel 24 hours a day, seven days a week.

108.10(4) *Record.* An agency shall maintain a record for each child in a supervised apartment living placement. The record shall contain all of the following:

a. The name, date of birth, sex, and address of the child and information on how the child can be contacted.

b. Documentation of financial support sufficient to meet the child's housing, clothing, food, and miscellaneous expenses.

c. Name, address, and phone number of guardian, if applicable, and referring agent.

d. Medical records.

e. Educational and employment records.

f. All of the individual service plans and updated reviews.

g. Documentation of visits.

108.10(5) *Staffing requirements.* Each child in a supervised apartment living placement shall receive an agreed-upon number of hours of casework services per month. This shall be recorded in the child's individual service plan.

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TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
PURCHASE OF SERVICE

[Prior to 7/1/83, Social Services[770] Ch 145]
[Previously appeared as Ch 145—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

441—150.1(234) Definitions.

"Accounting year" means a 12 consecutive month period for which accounting records are maintained. It can be either a calendar year or another designated fiscal year.

"Accrual basis accounting" means the accounting basis which shows all expenses incurred and income earned for a given time even though the expenses may not have been paid or income received in cash during the period.

"Administrative support" means technical assistance, studies, surveys, or securing volunteers to assist the department in fulfilling its administrative responsibilities.

"Agency" means an organization or organizational unit that provides social services.

1. Public agency means a general or special-purpose unit of government and organizations administered by that unit to deliver social services, for example, county boards of supervisors, community colleges, and state agencies.

2. Private nonprofit agency means a voluntary agency operated under the authority of a board of directors for purposes other than generating profit and incorporated under Iowa Code chapter 504A. An out-of-state agency must meet requirements of similar laws governing nonprofit organizations in its state.

3. Private proprietary agency means a for-profit agency operated by an owner or board for the operator's financial benefit.

"Bureau of purchased services" means a bureau of the division of fiscal management, which is responsible for administering the purchase of service system.

"Cash basis accounting" means the accounting basis which records expenses when bills are paid and income when money is received.

"Ceiling" means the maximum limit for payment for a service which has been established by an administrative rule or by the Iowa Code specifically for that service.

"Client" means an individual or family group who has applied for and been found to be eligible for social services from the Iowa department of human services.

"Common ownership" means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

"Components of service" means the elements or activities that make up a specific service.

"Contract" means formal written agreement between the Iowa department of human services and another legal entity, except for those government agencies whose services are covered under provision of Iowa Code chapter 28E.

"Contractor" means an institution, organization, facility or individual who is a legal entity and has entered into a contract with the department of human services.

"Control" means that relationship existing where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Department" means the Iowa department of human services.

"Direct cost" means those expenses which can be identified specifically and solely to a particular program.

"Donor" means a local source of funding (public or private) that enters into an Iowa donation of funds contract.

"Effective date."

1. Contract effective date for agency contracts means the first day of a month on which the contract shall become in force.

2. Effective date of rate means the date specified in a purchase of service contract on which the specified rate of payment for service provided begins.

"Field staff" means department employees outside of central office reporting to the deputy director of field operations.

"Grant" means an award of funds to develop specific programs or achieve specific outcomes.

"Indirect cost" means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

"Project manager" means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

"Provider" means an institution, organization, facility, or individual who is a legal entity and has entered into a contract with the department to provide social services to clients of the department.

"Purchase of service system" means the system within the department for contracting and payment for services, including contracts for funding and contracts for technical assistance.

"Related to provider" means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

"Relatives" include the following persons: husband and wife, natural parent and child, sibling, adopted child and adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent and grandchild.

"Social services" means a set of actions purposefully directed toward human needs which are socially identified as requiring assistance from others for their resolution.

"Unit of service" means a specified quantity of service or a specific outcome as a result of the service provided.

441—150.2(234) Categories of contracts.

150.2(1) *Iowa purchase of social services contract.* An Iowa purchase of social services contract is a legal contract between the department and a provider for a specified service or services to clients referred by the department. This contract establishes the components of service to be provided, the rate per unit of service, a maximum number of units to be available, and other negotiated conditions. The department has three types of contracts for purchasing social services.

a. An agency contract is a contract written with an agency. Iowa Purchase of Social Services Agency Contract, Form 470-0628, shall be completed prior to services being purchased from the agency.

b. A child care certificate is an agreement written with a licensed child care center, a family day care home, a group day care home, an in-home care provider, or a relative care provider. Policies governing child care certificates may be found in 441—Chapter 170.

c. An individual in-home health-related provider agreement is an agreement written with an individual provider of in-home health services. Policies governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

150.2(2) *Iowa purchase of administrative support contract.* An Iowa purchase of administrative support contract is between the department and a contractor for the provision of administrative support. This contract establishes the support services to be provided, the rate and the method of payment, and other negotiated conditions. A contractor or the division of a contractor who is a multiservice organization holding an administrative support contract may not provide direct client services during the period of the contract.

a. A volunteer contract is the administrative support contract between an individual or agency and the department to secure volunteers to assist the department in service delivery.

b. A general use administrative support contract is between the department and a contractor for the provision of administrative support.

150.2(3) *County board of supervisors' participation contract.* Rescinded IAB 7/8/92, effective 7/1/92.

150.2(4) *Iowa donation of funds contract.* The department may accept donated funds.

a. Upon mutual agreement regarding the scope and use of the funds to be donated, the department may negotiate and shall execute a contract between the department and the donor in accordance with department of administrative services rules in 11—Chapters 106 and 107. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds.

b. Except for restrictions permitted by the contract, all funds shall be donated on an unrestricted basis for use as if they were appropriated funds and shall be under the administrative control of the department. The donor may specify the geographic area to be served and the specific service to be provided.

c. No funds donated and transmitted to the department will be returned to the donor unless specified in the contract.

441—150.3(234) Iowa purchase of social services agency contract.

150.3(1) *Initiation of contract proposal.* When the department issues a request for proposal to select providers, the process and conditions for approving contract proposals shall be as specified in the request, and the department shall not be required to contract with a provider that is not selected. Otherwise, the following procedures for initiation of contract proposals shall apply.

a. *Right to request a contract.* All potential provider agencies have a right to request a contract.

b. *Initial contact.* The initial contact should be between the potential provider and the service area manager for the service area in which the provider's headquarters is located. In the case of out-of-state providers, this contact can be with the service area manager for either the closest service area or the service area initiating the contact. At the beginning of the process of developing a contract, the bureau of purchased services shall give the provider:

(1) Information about the contracting process; and

(2) Instructions on how to access the Purchase of Service Provider Handbook electronically.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This information shall include documentation that the conditions of participation are met. Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, shall be completed at the same time as Form 470-0628, Iowa Purchase of Social Services Agency Contract, or Form 470-0630, Amendment or Renewal of the Iowa Purchase of Social Services Agency Contract, is prepared.

d. *Contract proposal approval or rejection.* Before a contract can be effective, it shall be signed by the following persons within the time frames provided:

(1) Authorized representative of the provider agency.

(2) Service area manager, within one week from receipt.

(3) Rescinded IAB 5/11/05, effective 5/1/05.

(4) Chief of the bureau of purchased services, within 30 days from receipt.

The provider shall be given a notice and explanation in writing of delays in the process or of rejection of the proposal. Payment cannot be made until the contract is signed by the provider's authorized representative and the chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected:

(1) The service is not needed by department clients.

(2) The service is not in the social services block grant plan for the counties to be served by the program.

(3) No funds are available for the service being proposed.

(4) The proposed contract does not meet applicable rules, regulations, or guidelines, including service definition.

f. *Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the chief of the bureau of purchased services.

150.3(2) *Contract administration.*

a. *Contract management.* During the contract period the assigned project manager shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance, if needed. Report of On-Site Visit, Form 470-0670, may be used to monitor performance under the contract.

b. *Contract amendment.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of services shall include reestablishment of applicable rates. Amendment or Renewal of Iowa Purchase of Social Services Agency Contract, Form 470-0630, shall be used to amend or renew the contract.

c. *Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days before the expiration date.

(1) Each contract shall be evaluated. The department shall take the results of the evaluation into consideration in making the decision on renewal. This evaluation may involve use of the Monitoring and Evaluation Review Guide, Form 470-2571, or other evaluation tools specified in the contract.

(2) Desk Audit for Civil Rights Contract Compliance, Form 470-2215, shall be completed by the provider.

d. *Contract termination.* Causes for termination during the period of the contract are:

(1) Mutual agreement of the parties involved.

(2) Demonstration that sufficient funds are unavailable to continue the services involved.

(3) Failure to make required reporting.

(4) Failure to make financial and statistical records available for review.

(5) Failure to abide by the provisions of the contract.

150.3(3) *Conditions of participation.* The provider shall meet the following standards:

a. *Licensure, approval, or accreditation.* The provider shall have any license, approval, and accreditation required by law, regulation or administrative rules, or standards of operation required by the state or the federal government before the contract can be effective. Out-of-state providers shall meet Iowa licensing standards related to treatment, professional staff to client ratio, and staff qualifications.

b. *Signed contract.* A contract can be effective only when signed by all parties required in 150.3(1)*"d."*

c. *Civil rights laws.* The providers shall be in compliance with all federal, state and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

d. *Title VI compliance.* The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

e. *Section 504 compliance.* The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, Plan Review Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

f. *Affirmative action.* The provider shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

g. *Abuse reporting.* The provider shall have a written policy and procedure approved by the service area manager or designee for reporting abuse or denial of critical care of children or dependent adults.

h. *Confidentiality.* The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure approved by the service area manager or designee for maintaining individual client confidentiality including client record destruction.

i. *Client appeals and grievances.* Clients receiving service through a purchase of service contract have the right to appeal adverse decisions made by the department or the provider. The provider shall have a written policy and procedure approved by the service area manager or designee for handling client appeals and grievances and shall provide information to clients about their rights to appeal.

j. *Client reports.* The provider shall maintain the following client records:

(1) Provider service plan or individual program plan. Providers shall develop a written service plan or individual program plan for each client within 30 days of service initiation. The plan shall include a concise description of the situation or area which will be the focus of the service; statement of the goals to be achieved through the delivery of services; time limited and measurable objectives which will lead to the attainment of the goal to be achieved; specific service components, frequency, and the assignment of responsibility for the provision of the components; and the month and year when it is estimated the client will be able to achieve the current goals and objectives. The provider service plan shall be updated upon receipt of a new departmental case plan, but at least once every six months.

(2) Quarterly progress reports. Quarterly progress reports shall be sent to the department service worker responsible for the client. The first report shall be submitted to the department three months after service is initiated. Reports shall be submitted quarterly thereafter, unless provided for otherwise in rules for a specific service.

The progress report shall include a description of the specific service components provided, their frequency, and who provided them; the client's progress with respect to the goals and service objectives; and any recommended changes in the service plan or individual program plan. For all placement cases the report shall include interpretation of the client's reaction to placement, a summary of medical or dental services that were provided, a summary of educational or vocational progress and participation, and a summary of the involvement of the family with the client and the services.

Reports for the supervised apartment living service shall also include supporting documentation for service provision. The documentation shall list dates of client and collateral contacts, type of contact, persons contacted, and a brief explanation of the focus of each contact. Each unit of service for which payment is sought should be the subject of a written progress note.

(3) Termination of service summary. A termination of service summary shall be sent to the department service worker responsible for the client within two weeks of service termination. The summary shall include the rationale for service termination and the impact of the service components on the client in relationship to the established goals and objectives.

k. *Financial and statistical records.* Each provider of service must maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, and state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

l. *Reports on financial and statistical records.* Reports on financial and statistical records shall be submitted as required. Failure to do so within the required time limits is grounds for termination of the contract.

m. Maintenance of client records. Records for clients served through a purchase of service contract must be retained by the provider for a period of three years after service to the client terminates.

n. Provider charges. A provider shall not charge department clients more than it receives for the same services provided to nondepartmental clients.

o. Special-purpose organizations. A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or nonclient-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, a special-purpose organization is considered to be related to a provider if:

(1) The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies; or

(2) The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with intent of benefiting the provider.

The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider; or

The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

p. Certification by department of transportation.

(1) If the provider furnishes public transit service as defined in 761—910.1(324A), the provider shall annually submit to the project manager information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

1. Form 020107, Certification Application for Coordination of Public Transit Services, which the project manager shall submit to the department of transportation; and

2. A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

(2) If a provider believes it does not furnish public transit service as defined in 761—910.1(324A) and therefore is exempt from the requirements in subparagraph (1), the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

(3) If a provider that has furnished public transit service as defined in 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in subparagraph (1).

(4) If an exempt provider begins to furnish public transit service as defined in 761—910.1(324A), the provider shall inform the project manager within 30 days of the change and shall adhere to the procedures in subparagraph (1).

(5) Failure of the provider to cooperate in obtaining or providing the required documentation for compliance or exemption is grounds for denial or termination of the contract.

q. Services provided. Services provided, as described in Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, and attachments, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular service or the contract may be terminated.

r. Bonding, indemnity and insurance clauses.

(1) Rescinded IAB 2/3/93, effective 4/1/93.

(2) Indemnity. The provider agrees that it will at all times during the existence of this contract indemnify and hold harmless the department and county against any and all liability, loss, damages, costs or expenses which the provider may hereafter sustain, incur or be required to pay:

1. By reason of any client's suffering personal injury, death or property loss or damages either while participating in or receiving from the provider the care and services to be furnished by the provider under this contract, or while on premises owned, leased, or operated by the provider, or while being

transported in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the provider or any officer, agency, or employee thereof.

2. By reason of any client's causing injury to or damage to another person or property during any time when the provider or any officer, agency or employee thereof has undertaken or is furnishing the care and service called for under this contract.

(3) Insurance. The provider agrees that in order to protect itself as well as the department and county under the indemnity agreement above, it will at all times during the term of the contract have and keep in force a liability insurance policy, verification of which shall accompany Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet. The provider agrees that all employees, volunteers, or any other person, other than employees of the department acting within the scope of their employment in the department, authorized to transport clients in privately owned vehicles, have liability insurance in force.

s. Renegotiation clause. In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

t. Performance measures. The department may require performance measures.

150.3(4) *Establishment of rates.* The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, is the basis for establishing the rates to be paid to all providers under an Iowa Purchase of Social Services Agency Contract, Form 470-0628, except as provided below.

a. Injectable contraceptive unit. Rescinded IAB 8/1/07, effective 9/5/07.

b. Out-of-state providers.

(1) Rescinded IAB 9/1/93, effective 11/1/93.

(2) Out-of-state providers of other services shall have rates established using the applicable portions of the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664.

c. Family-centered flexible supportive services. Rescinded IAB 5/6/09, effective 7/1/09.

150.3(5) *Financial and statistical report.* The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, shall be completed by those providers as required in 150.3(4). The reports shall be based on the following rules.

a. Accounting procedures. Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers who are multiple program agencies shall submit a cost allocation schedule prepared in accordance with recognized methods and procedures.

(1) Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor supervises more than one program.

(2) Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program. They may also be charged as direct program expenses when a method of distribution acceptable to the department is maintained on a consistent basis.

(3) Occupancy expenses shall be allocated to programs on a space utilization formula. The space utilization formula may be used for salaries and fringes of building maintenance and janitorial type personnel.

(4) All expenses which relate jointly to two or more programs shall be allocated to program service costs by utilizing a cost allocation method which fairly distributes costs to the related programs. Any expenses which relate directly to a particular program shall be reflected as such. All maintenance costs shall be charged directly or allocated proportionately to the related programs affected.

(5) Indirect program service costs shall be distributed over all applicable services.

(6) Expenses such as supplies, conferences, and similar expenses that cannot be directly related to a program shall be charged to indirect program service costs.

(7) A multiservice agency shall establish a method acceptable to the department of distributing indirect program service costs.

(8) Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

If a shelter care provider's actual and allowable costs for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs, or the statewide average of actual and allowable costs in May of the preceding year for juvenile shelter care homes, whichever is less.

(9) When an agency has a certified public accounting firm perform an audit of its financial statements, the resulting audit report shall follow one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants. These formats are specified in the industry audit guide series, "Audits of Voluntary Health and Welfare Organizations," prepared by the Committee on Voluntary Health and Welfare Organizations, American Institute of Certified Public Accountants, New York, 1974. A copy of the certified audit report shall be submitted to the department within 60 days of receipt.

(10) All expenses reported on Form 470-0664 shall be supported by an agency's general ledger and documentation on file in the agency's office.

b. Failure to maintain records. Failure to maintain records adequate to support the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, may result in termination of the contract. These records include, but are not limited to:

(1) Reviewable, legible census reports.
(2) Payroll information.
(3) Capital asset schedules.
(4) All canceled checks, deposit slips, invoices (paid and unpaid).
(5) Audit reports (if any).
(6) Board of directors' minutes.

c. Submission of reports. The financial and statistical report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. At least one week must be allowed prior to this deadline for the project manager to review the report and transmit it to the bureau of purchased services in central office. Failure to submit the report in time without written approval from the chief of the bureau of purchased services may reduce payment to 75 percent of the current rate. Failure to submit the report within six months of the end of the fiscal year shall be cause for terminating the contract.

d. Rate modification. Modification of rates shall be made when required by changes in licensing requirements, changes in the law, or amendments to the contract. Requests for modification of a rate may be made when changes are because of program expansion or modification and have the approval of the service area where services are provided. Even if there is a modification of the rate, the modified rate is still subject to any maximum established in any law or rule.

e. Payment of new rate. New rates shall be effective for services provided beginning the first day of the second calendar month after receipt by the bureau of purchased services of a report sufficient to establish rates or, by mutual agreement, new rates shall be effective the first day of the month following completion of the fiscal review. Failure to submit a report sufficient to establish a rate will result in the effective date's being delayed. At least one week must be allowed prior to the deadline in paragraph *"c"* above for the project manager to review the report and transmit it to central office.

f. Exceptions to costs. Exceptions to costs identified by the bureau of purchased services or its fiscal consultant will be communicated to the provider in writing.

g. *Accrual basis.* Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

h. *Census data.* Documentation of units of service provided which identifies the individual client shall be available on a daily basis and summarized on a monthly report. The documentation and reports shall be retained by the provider for review at the time the expenditure report is prepared and reviewed by the department's fiscal consultant.

i. *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

j. *Revenues.* When the Financial and Statistical Report is completed, revenues shall be reported as recorded in the general books and records adjusted for accruals. Expense recoveries shall be reflected as revenues.

k. *Capital asset use allowance (depreciation) schedule.* The Capital Asset Use Allowance Schedule shall be prepared using the guidelines for provider reimbursement in the Medicare and Medicaid Guide, December 1981.

l. *The following expenses shall not be allowed:*

(1) Fees paid directors and nonworking officers' salaries.

(2) Bad debts.

(3) Entertainment expenses.

(4) Memberships in recreational clubs, paid for by an agency (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the employees of the agency.

(5) Legal assistance on behalf of clients.

(6) Costs eligible for reimbursement through the medical assistance program.

(7) Food and lodging expenses for personnel incurred in the city or immediate area surrounding the personnel's residence or office of employment, except when the specific expense is required by the agency and documentation is maintained for audit purposes. Food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, guardians, or consultants are allowable expenses when documentation is available for audit purposes.

(8) Business conferences and conventions. Meeting costs of an agency which are not required in licensure.

(9) Awards and grants to recognize board members and community citizens for achievement. Awards and grants to clients as part of treatment program are reimbursable.

(10) Survey costs when required certification is not attained.

(11) Federal and state income taxes.

m. *Limited service—without a ceiling.* The following expenses are limited for service without a ceiling established by administrative rule or law for that service. This includes services with maximum rates, with the exception of shelter care.

(1) Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of locating qualified individuals for staff positions are allowed for reimbursement purposes.

(2) and (3) Rescinded IAB 5/18/88, effective May 1, 1988.

(4) Costs for participation in educational conferences are limited to 3 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report.

(5) Costs of reference publications and subscriptions for program-related materials are limited to $500 per year.

(6) Memberships in professional service organizations are allowed to the extent they do not exceed one-half of 1 percent of the total salary costs less excluded salary costs.

(7) In-state travel costs for mileage and per diem expenses are allowable to the extent they do not exceed the maximum mileage and per diem rates for state employees for travel in the state.

(8) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (7) above.

(9) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is $40,000 annually.

(10) Annual meeting costs of an agency which are required in licensure are allowed to the extent required by licensure.

n. Limited service—with a ceiling. The following expenses are limited for services with a ceiling established by administrative rule or law for that service. This includes shelter care.

(1) The maximum reimbursable compensation for the agency administrator or executive director charged to purchase of service annually is $40,000.

(2) Annual meeting costs of an agency which are required for licensure are allowed to the extent required by licensure.

o. Establishment of ceiling and reimbursement rate.

(1) The maximum allowable rate ceiling applicable to each service is found in the rules for that particular service.

(2) When a ceiling exists, the reimbursement rate shall be established by determining on a per unit basis the allowable cost plus the current cost adjustment subject to the maximum allowable cost ceiling.

p. Rate limits. Interruptions in service programs will not affect the rate. If an agency assumes the delivery of service from another agency, the rate shall remain the same as for the former agency.

(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the financial and statistical report submitted to the department. For the fiscal year beginning July 1, 2008, the maximum reimbursement rate shall be $92.36 per day, based on a 365-day year. If the department reimburses the provider at less than the maximum rate, the department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost plus the inflation factor or to the maximum reimbursement rate, whichever is less.

(2) For the fiscal year beginning July 1, 2010, the reimbursement rates for supervised apartment living service providers shall be increased by 1.31 percent over the rates in effect on June 30, 2010.

(3) The initial reimbursement rate for any new service shall be based upon actual and allowable costs. A new service does not include a new building or location or other changes in method of service delivery for a service currently provided under the contract.

1. For shelter care, if the provider is currently offering shelter care under social services contract, the only time the provider shall be considered to be offering a new service is if the provider adds a service other than shelter care.

2. For supervised apartment living, the only time a provider shall be considered to be offering a new service is when the agency adds a cluster site or a scattered site for the first time. If, for example, the agency has a supervised apartment living cluster site, the addition of a new site does not constitute a new service.

3. If the department defines, in administrative rule, a new service as a social service that may be purchased, this shall constitute a new service for purposes of establishment of a rate. Once the rate for the new service is established for a provider, the rate will be subject to any limitations established by administrative rule or law.

(4) If a social service provider loses a source of income used to determine the reimbursement rate for the provider, the provider's reimbursement rate may be adjusted to reflect the loss of income, provided that the lost income was used to support actual and allowable costs of a service purchased under a purchase of service contract.

q. Related party costs. Direct and indirect costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider are includable in the allowable cost of the provider at the cost to the related organization. All costs allowable at the provider level are also allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

(1) Allowable costs shall be all actual direct and indirect costs applying to any service or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

(2) When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a schedule displaying amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 150.3(5)*"a"*(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in 150.3(3)*"k."*

(3) Tests for relatedness shall be those specified in rule 441—150.1(234) and 150.3(3)*"o."* The department or the purchase of service fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and list of board members.

r. *Day care increase.* Rescinded IAB 7/7/93, effective 7/1/93.

s. *Interest on unpaid invoices.* Any invoice that remains unpaid after 60 days following the receipt of a valid claim is subject to the payment of interest. The rate of interest is 1 percent per month beyond the 60-day period, on a simple interest basis. A separate claim for the interest is to be generated by the agency. If the original claim was paid with both federal and state funds, only that portion of the original claim paid with state funds will be subject to interest charges.

t. *Interest as an allowable cost.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) "Interest" is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably required to operate a program, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

u. *Rate formula.* Paragraph 150.3(5)*"p"* notwithstanding, when rates are determined based on cost of providing the service involved, they will be calculated according to the following mathematical formula:

$$\frac{\text{Net allowable expenditures}}{\text{Effective utilization level}} \times \text{Reimbursement factor} = \text{Base Rate}$$

(1) Net allowable expenditures are those expenditures attributable to service to clients which are allowable as set forth in subrule 150.3(5), paragraphs *"a"* to *"t."*

(2) Effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

(3) Inflation factor is the percentage which will be applied to develop payment rates consistent with current policy and funding of the department. The inflation factor is intended to overcome the time lag between the time period for which costs were reported and the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(4) Base rate is the rate which is developed independent of any limits which are in effect. Actual rates paid are subject to applicable limits or maximums.

v. Rescinded IAB 5/13/92, effective 4/16/92.

150.3(6) *Client eligibility and referral.*

a. Program eligibility. To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the department.

(1) The department shall not make payment for services provided before the client's application, eligibility determination, and referral. See *"b"* below for an exception to this requirement.

(2) Except as provided in paragraph *"c,"* the department shall use the following forms to authorize services:

1. Form 470-0622, Referral of Client for Purchase of Social Services.
2. Form 470-0719, Placement Agreement: Child Placing or Child Caring Agency (Provider).

b. When a court orders foster care and the department has no responsibility for supervision or placement of the client, the department will pay the rate established by these rules for maintenance and service provided by the facility.

c. Family-centered services. For family-centered services, the provisions in rule 441—172.3(234) relating to approval, authorization, and referral shall apply.

150.3(7) *Client fees.* The provider shall agree not to require any fee for service from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy. Rules governing client fees are found in 441—130.4(234).

The provider shall collect fees due from clients. The provider shall maintain records of fees collected, and these records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment. When the second notice of nonpayment is sent, the provider shall send a copy of the notice to the department worker.

150.3(8) *Billing procedures.* At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred, each service, and each funding source involved in payment. Complete invoices shall be sent to the departmental county office responsible for the client for approval and forwarding for payment.

More frequent billings may be permitted on an exception basis with the written approval of the service area and the chief of the bureau of purchased services.

a. Time limit for submitting vouchers, invoices, or claims. The time limit for submission of original vouchers, invoices, or claims shall be three months from the date of service.

b. Resubmittals of rejected claims. Valid claims which were originally submitted within the time limit specified in paragraph *"a"* but were rejected because of an error shall be resubmitted without regard to time frames.

150.3(9) *Reviews of departmental actions.* A provider who is adversely affected by a departmental decision may request a review. A review request may cause the action to be stopped pending the outcome of the review, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. The provider shall send a written request for review to the project manager responsible for the contract within ten days of receipt of the decision in question. This request shall document the specific area in question and the remedy desired. The project manager shall provide a written response within ten days.

b. When dissatisfied with the response, the provider shall submit to the service area manager within ten days the original request, the response received, and any additional information desired. The service area manager shall study the concerns and the action taken, and render a decision in writing within 14 days. A meeting with the provider may be held to clarify the situation.

c. If still dissatisfied, the provider may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs *"a"* and *"b"* above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting may be held with the provider, project manager, and service area manager or designee.

d. The provider may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.3(10) *Review of financial and statistical reports.* Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider.

The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.3(5). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

150.3(11) Rescinded, effective 3/1/87.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8447B**, IAB 1/13/10, effective 1/1/10; **ARC 8651B**, IAB 4/7/10, effective 5/12/10; **ARC 8902B**, IAB 6/30/10, effective 7/1/10]

441—150.4(234) Iowa purchase of social services contract—individual providers.

150.4(1) *Individual child day care provider agreement.* Rules governing individual child day care provider agreements may be found in 441—Chapter 170.

150.4(2) *Individual in-home health-related provider agreement.* Rules governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

441—150.5(234) Iowa purchase of administrative support.

150.5(1) *Initiation of contract proposal.*

a. *Right to request a contract.* All potential contractors have a right to request a contract.

b. *Initial contact.*

(1) Volunteer contract. The initial contact for a volunteer contract may be between the potential contractor and the service area manager of the service area in which the individual or the contractor agency's headquarters is located or the contract may be between the potential contractor and the director of the state volunteer program in the central office of the department. If so, the director will communicate with the service area.

(2) General use administrative support contract. The initial contact for a general use administrative support contract may be between the potential contractor and the service area manager of the service area in which the individual or contractor organization's headquarters is located or the contract may be between the potential contractor and the chief of the bureau of purchased services, who will communicate with the service area.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This includes documentation that the conditions of participation required below are met.

d. *Contract proposal approval or rejection.* Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Volunteer contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Director of the state volunteer program within 30 days from receipt.

(2) General use administrative support contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Chief of the bureau of purchased services within two weeks from receipt.

Administrator of the division of fiscal management within two weeks from receipt.

The contractor shall be notified of delays in the process or of rejection of the proposal. This notification along with an explanation shall be in writing. The applicant has a right to have the decision reviewed by the director of the state volunteer program, or chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected.

(1) The proposed activity is not needed by the department.

(2) No funds are available for the activity being proposed.

(3) The proposed contract does not meet applicable rules, regulations, or guidelines.

f. *Contract effective date.* If the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the director of the state volunteer program, or the chief of the bureau of purchased services.

150.5(2) *Contract administration.*

a. *Contract management.* During the contract period, the assigned project manager shall be the liaison between the department and the contractor. The project manager shall be contacted on all interpretations and problems related to the contract and shall follow issues through to their resolution. The project manager shall also monitor performance under the contract and will provide or arrange for technical assistance to improve the contractor's performance, if needed.

b. *Contract amendments.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of providing the volunteer services must include reestablishment of amounts to be paid.

c. *Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days prior to the expiration date. Each contract shall be evaluated. The results of the evaluation shall be taken into consideration in the decision on renewal. This evaluation may involve use of evaluation tools specified in the contract.

d. *Contract termination.* Causes for termination during the period of the contract are:

(1) Mutual agreement of the parties involved.

(2) Demonstration that sufficient funds are unavailable to continue the service(s) involved.

(3) Failure to make reports required by the contract.

(4) Failure to make financial, statistical, and program records available.

(5) Failure to abide by the provisions of the contract.

150.5(3) *Conditions of participation.* The contractor shall meet the following standards:

a. *Licensure, approval, or accreditation.* The contractor shall have any license, approval, and third-party accreditation required by law, regulation, or administrative rules, or shall meet standards of operation required by state or federal regulation. This requirement must be met before the contract can be effective.

b. *Signed contract.* A contract can be effective only when signed by all parties required in 150.5(1)*"d."*

c. *Civil rights laws.* The contractors shall be in compliance with all federal, state, and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance.

d. *Title VI compliance.* The contractors shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance.

e. *Section 504 compliance.* The contractors shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance.

f. *Affirmative action.* The contractors shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance.

g. *Abuse reporting.* The contractor shall have an approved policy and procedure for reporting abuse or denial of critical care of children or dependent adults.

h. *Confidentiality.* The contractor shall comply with all applicable federal and state laws and regulations on confidentiality.

i. *Financial and statistical records.* Each contractor of service shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, or state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

j. *Certification by department of transportation.* Each contractor who supplies transportation services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of "Certificate of Insurance" (an ACORD form or similar or self-insurance documentation) to the applicable project manager annually showing information regarding compliance with, or exemption from, public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to provide the required documentation for compliance or exemption is grounds for denial or termination of the contract.

150.5(4) *Establishing amounts to be paid.* The amounts to be paid under purchase of administrative support contracts are actual approved expenses as negotiated in the contract. Approved items of cost are based on submission of a proposed budget listing those items necessary for provision of the volunteer coordination or technical assistance to be delivered. At the termination of the contract a statement of actual expenses incurred shall be submitted by the contractor.

150.5(5) *Billing procedures.* At the end of each month, or as otherwise provided in the contract, the contractor shall prepare a claim on Form GAX, General Accounting Expenditure, for expenses for which reimbursement is permitted in the contract. The claim shall be sent to the office of the department that administers the contract for approval and forwarding for payment.

a. *Time limit for submitting claims.* The time limit for submission of original claims shall be within 90 days of the provision of service.

b. *Resubmittals of rejected claims.* Valid claims which were originally submitted within this time limit but were rejected because of an error must be resubmitted, but without regard to time frames.

150.5(6) *Reviews of department actions.* A contractor who is adversely affected by a department decision may request a review. A review request may cause the action to be stopped pending the outcome of the review process, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. Within ten days of receipt of the decision in question the contractor shall send a written request for review to the project manager responsible for the contract. This request shall document the specific area in question and the remedy desired. A written response from the project manager shall be provided within ten days.

b. When dissatisfied with the response, the contractor shall submit the original request, the response received, and any additional information desired to the service area manager within ten days. The service area manager shall study the concerns, the action taken and render a decision in writing within 14 days. A meeting with the contractor may be held to clarify the situation.

c. If still dissatisfied, the contractor may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs *"a"* and *"b"* above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting with the contractor, project manager, and service area manager or designee may be held.

d. The contractor may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.5(7) *Reviews.* Authorized representatives of the department or state or federal audit personnel have the right to review the general financial records of a contractor. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.5(4). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may be on the basis of an on-site visit to the contractor, the contractor's central accounting office, the offices of the contractor's agents, a combination of these, or, by mutual decision, to other locations.

This rule is intended to implement Iowa Code sections 234.6 and 324A.5, subsection 3, paragraph *"c."*

441—150.6(234) County board of supervisors participation contract. Rescinded IAB 7/8/92, effective 7/1/92.

441—150.7(234) Iowa donation of funds contract. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.8(234) Provider advisory committee. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.9(234) Public access to contracts. Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 2001 Iowa Acts, House File 732, section 31, subsection 6, and Senate File 537, section 1, subsection 1, paragraph *"d."*

441—150.10 to **150.20** Reserved.

DIVISION II
PURCHASE OF SOCIAL SERVICES CONTRACTING ON BEHALF OF COUNTIES FOR LOCAL PURCHASE SERVICES FOR ADULTS WITH MENTAL ILLNESS, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES
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CHAPTER 152
FOSTER GROUP CARE CONTRACTING

PREAMBLE

This chapter sets forth the contracting process used for providers of foster group care services, including standards for rate-setting, payment mechanisms, and provider monitoring, audits, and sanctions. The term of the contract is limited to no more than six years pursuant to 11—Chapters 106 and 107. The rules also establish provider qualifications, service authorization procedures, documentation requirements, and service termination and appeal procedures associated with foster group care services. Refer to 441—Chapter 156 for additional program requirements.

441—152.1(234) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Authorized representative," within the context of rule 441—152.9(234), means that person appointed to carry out audit procedures, including an assigned auditor, fiscal consultant, or agent contracted for a specific audit or audit procedure.

"Child" means a person under 18 years of age or a person 18 or 19 years of age who meets the criteria in Iowa Code section 234.1.

"Claim" means each record the department receives that tells the amount of requested payment and the service rendered by a provider to a child and family.

"Client" means a child who has been found to be eligible for foster group care services through the Iowa department of human services.

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

"Contract" means a formal written agreement between the Iowa department of human services and a provider of foster group care services.

"Contract monitor" means a department employee who is assigned to assist in developing, monitoring, and evaluating a contract and to provide related technical assistance.

"Department" means the Iowa department of human services.

"Extrapolation" means that the total dollars of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Family," for purposes of child welfare service delivery, shall include the following:

1. The natural or adoptive parents, stepparents, and children who reside in the same household.
2. A child who lives with an adult related to the child within the fourth degree of consanguinity and the adult relatives within the fourth degree of consanguinity in the child's household who are responsible for the child's supervision. Relatives within the fourth degree of consanguinity include: full or half siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great-nephews, grandparents, great-grandparents, great-great-grandparents, and first cousins.
3. A child who lives alone or who resides with a person or persons not legally responsible for the child's support.

"Fiscal record" means a tangible and legible history that documents the criteria established for financial and statistical records as set forth in subrule 152.2(7).

"Grant" means an award of funds to develop specific programs or achieve specific outcomes.

"Host area" means:

1. The department service area where the provider's corporate office is located, or
2. The service area designated by the chief of the bureau of purchased services when the provider's corporate office is out of state.

"Juvenile court officer" means a person appointed as a juvenile court officer or chief juvenile court officer under Iowa Code chapter 602.

"Level of care" means a type of foster group care service that is differentiated by the ratio of staff to children. There are three levels of foster group care services:

1. Community-level group care (service code D1), which requires a minimum staff-to-client ratio of 1 to 8 during prime programming time.
2. Comprehensive-level group care (service code D2), which requires a minimum staff-to-client ratio of 1 to 5 during prime programming time.
3. Enhanced comprehensive-level group care (service code D3), which requires a minimum staff-to-client ratio during prime programming time as follows:

- 1 staff person for facilities serving up to 4 children.
- 2 staff persons for facilities serving 5 to 7 children.
- 3 staff persons for facilities serving 8 to 10 children.
- 4 staff persons for facilities serving 11 to 13 children.
- 5 staff persons for facilities serving 14 to 16 children.
- 6 staff persons for facilities serving 17 to 19 children.
- 1 staff person for every 3 children for facilities serving 20 or more children.

"Nonprime programming time" means any period of the day other than prime programming time and sleeping time.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to foster group care services and results in a payment greater than that to which the provider is entitled.

"Prime programming time" means any period of the day when special attention, supervision, or treatment is necessary (for example, upon awakening of the clients in the morning until their departure for school, during meals, after school, during transition between activities, evenings and bedtime, and on nonschool days such as weekends, holidays, and school vacations).

"Probation" means a specified period of conditional participation in the provision of foster group care services.

"Provider" means any natural person, company, firm, association, or other legal entity that is seeking a contract or is under contract with the department pursuant to this chapter.

"Random sample" means a systematic (or every "nth" unit) sample for which each item in the universe has an equal probability of being selected.

"Referral worker" means the department worker or juvenile court officer who refers the case to a provider and who is responsible for carrying out the follow-up activities of determining client eligibility and ensuring that the service authorization is completed.

"Service authorization" means the process of determining service necessity and the level of care and number of units of service to be provided to a child.

"Service record" means an individual, tangible, and legible file that records service-related activities set forth in subrule 152.2(6).

"Site" means a location from which services are delivered or where staff report or records are kept. In the foster group care programs, each separately licensed location is a site.

"Sleeping time" means any period of the day during which clients are normally sleeping.

"Suspension of payments" means the withholding of all payments due a provider until resolution of the matter in dispute between the provider and the department.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the foster group care services program and to which the provider is entitled.

"Unit of service" means one day.

"Universe" means all items (claims) submitted by a specific provider for payment during a specific period, from which a random sample will be drawn.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

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441—152.2(234) Conditions of participation.

152.2(1) *Provider licensure.* The department shall enter into a contract with a provider for foster group care services only when the provider's facility has achieved full licensure as follows:

a. A facility providing community-level group care shall be licensed:

(1) As a community residential facility pursuant to 441—Chapter 114;

(2) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(3) Under comparable standards by the state in which the facility is located.

b. A facility providing comprehensive-level group care shall be licensed:

(1) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(2) Under comparable standards by the state in which the facility is located.

c. A facility providing enhanced comprehensive-level group care shall be licensed:

(1) As a comprehensive residential facility pursuant to 441—Chapter 115; or

(2) Under comparable standards by the state in which the facility is located.

152.2(2) *Provider staffing.* At a minimum, all providers shall meet the requirements for staff qualifications, training, and number of staff pursuant to 441—Chapter 114 or as identified in appendices to Form 470-3052, Foster Group Care Services Contract.

a. All foster group care programs shall provide an appropriate number of hours of prime programming time sufficient to meet the child welfare service needs of the children served in the program.

b. Staffing during prime programming time, nonprime programming time, and sleeping time shall be sufficient to meet the group care maintenance needs of the children served in the program.

152.2(3) *Services provided.* The provider shall comply with the requirements for services to be provided, as described on Form 470-3051, Foster Group Care Services Contract Face Sheet, and appendices to Form 470-3052, Foster Group Care Services Contract. These services shall at a minimum meet the requirements found in 441—Chapter 156 and in 441—Chapter 114 or 441—Chapters 114 and 115, as applicable, or the contract may be terminated.

152.2(4) *Provider charges.* A provider shall not charge departmental clients more than it receives for the same foster group care services provided to nondepartmental clients. The provider shall agree not to require any fee from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy.

152.2(5) *Compliance with the law.* The provider and its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, and orders when performing services under the contract.

a. *Drug-free workplace.* The provider shall operate a drug-free workplace.

b. *Use of funds.* The provider shall:

(1) Agree that federally appropriated funds shall not be paid on behalf of the department or provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with:

1. The awarding of any federal contract,
2. The making of any federal grant,
3. The making of any federal loan,
4. The entering into of any cooperative agreement, or
5. The extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

(2) Ensure that no funds received or expended will be used in any way to promote or oppose unionization.

152.2(6) *Maintenance of service records.* A provider shall maintain complete and legible records as required in this subrule. A provider's client service records and case files for foster group care services shall comply with the requirements of this subrule and with the record-keeping requirements related to licensure pursuant to 441—Chapter 114.

a. The provider shall establish and maintain confidential, individual service records for each client receiving foster group care services. The service records must adequately support the provision of child welfare services and group care maintenance as defined in rule 441—156.1(234). The service record shall include, at a minimum, those items identified in rule 441—114.11(237) and the following:

(1) Additional reports, if requested by the referral worker;

(2) Form 470-3055, Referral and Authorization for Child Welfare Services;

(3) Daily documentation of billed per diem services as defined in paragraph *"b"*; and

(4) Notes indicating the child's general progress in regard to the child's care plan, entered no less than every seven calendar days.

b. Daily documentation of billed per diem services shall include:

(1) The child's first and last name;

(2) The month, day, and year service was provided;

(3) The first and last names of the persons who provided the service;

(4) A clear description of the specific service rendered, including interventions, actions, and activities performed which support the provision of child welfare services; and

(5) Any problem areas or unusual behavior for the child.

c. If individual case files include service records for services other than foster group care services, the provider has the responsibility to maintain the client records in compliance with all applicable rules.

d. The provider shall retain service records for clients receiving foster group care services for a period of not less than five years following the date of final payment or completion of any required audit or review, whichever is later. If any litigation, claim, negotiation, audit, review, or other action involving the records has been started before the expiration of the five-year period, the records must be retained until the later of:

(1) The completion of the action and resolution of all issues which arise from it, or

(2) The end of the regular five-year period.

e. Failure to maintain records or failure to make records available to the department or to its authorized representatives upon request may result in a notice of violation and recoupment of payments, pursuant to rules 441—152.9(234) and 441—152.10(234).

152.2(7) *Maintenance of financial and statistical records.* The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. The records shall be available for review at any time during normal business hours by department personnel, the department's fiscal consultant, and state or federal audit personnel.

a. At a minimum, financial and statistical records shall include all revenue and expenses supported by a provider's general ledger and documentation on file in the provider's office. These records include, but are not limited to:

(1) Payroll information.

(2) Capital asset schedules.

(3) All canceled checks, deposit slips, and invoices (paid and unpaid).

(4) Audit reports (if any).

(5) The board of directors' minutes (if applicable).

(6) Loan agreements and other contracts.

(7) Reviewable, legible census reports and documentation of units of service provided to departmental clients that identify the individual client and are kept on a daily basis and summarized in a monthly report.

(8) For nondepartmental clients, sufficient documentation of utilization to establish a complete unit of service count.

b. The provider shall maintain the following documentation for each program.

(1) A list of all staff and supervisors providing foster group care services and their qualifications.

(2) The number of staff hired and terminated in the year to date.

c. The documentation prepared by the provider shall be retained for use when any financial report is prepared and for review by the department's fiscal consultant. Financial records must be retained for five years from the date of report submission or final payment for services.

d. Independent audits. When a provider has an audit conducted, a firm not related to the provider shall conduct the audit. The provider shall submit a copy of the independent audit report to the department within 30 days of receipt of the report. The bureau of purchased services shall maintain the report and provide a copy of the report to the fiscal consultant.

152.2(8) *Special-purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain client-related or non-client-related activities on behalf of the provider. (For example, a provider may establish a development foundation to assume the provider's fund-raising activity.) Even if the provider does not own the special-purpose organization (e.g., a nonprofit, non-stock-issuing corporation) and has no common governing body membership, a separate special-purpose organization shall be considered a related party for purposes of this chapter when one of the following applies:

a. The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies.

b. For all practical purposes, the provider is the primary beneficiary of the organization's activities. The provider shall be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

(1) The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with the intent of benefiting the provider.

(2) The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider.

(3) The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

152.2(9) *Certification by department of transportation.*

a. If the provider furnishes public transit service as defined in rule 761—910.1(324A), the provider shall annually submit to the contract monitor information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

(1) Form 020107, Certification Application for Coordination of Public Transit Services, which the contract monitor shall submit to the department of transportation; and

(2) A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

b. If a provider believes it does not furnish public transit service as defined in rule 761—910.1(324A) and, therefore, is exempt from the requirements in paragraph *"a,"* the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

c. If a provider that has furnished public transit service as defined in rule 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in paragraph *"a."*

d. If an exempt provider begins to furnish public transit service as defined in rule 761—910.1(324A), the provider shall inform the contract monitor within 30 days of the change and shall adhere to the procedures in paragraph *"a."*

e. Failure of the provider to cooperate in obtaining or providing the required documentation of compliance or exemption is grounds for denial or termination of the contract.

152.2(10) *Copyright and patents.* The activities and results of contract activity may be published subject to confidentiality requirements.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.3(234) Determination of rates. Rates for foster group care services effective on or after November 1, 2006, shall be based on the historical payment rate negotiated between the provider and the department and shall be calculated based on rule 441—156.9(234).

152.3(1) *Negotiation of rates.* Rates for foster group care services effective on or after November 1, 2006, must be established in accordance with this subrule, except as provided in subrule 152.3(4).

a. All historical rate negotiations made under the former rehabilitative treatment and supportive services program on or after February 1, 1998, remain true and valid.

b. The scope of negotiations is limited solely to the rate to be paid for each service.

c. No other items, such as, but not limited to, changes in staff qualifications, service definition, required components, allowable costs or any licensing or other contractual requirements, shall be the subject of negotiations or be used as a basis for changing rates.

d. The service area manager of the host area is responsible for the negotiation of rates for each provider whose contract for foster group care services is administered by the host area, regardless of where the services are provided. Only the service area manager of the host area may approve the rates negotiated for a provider, except as provided in subrule 152.3(4).

(1) The service area manager of the host area shall take into consideration the other service areas served by a provider when negotiating a rate for a service provided in multiple service areas.

(2) When a service is provided only in a nonhost area, the two service area managers shall determine which one will negotiate the rate for that service.

e. The service area manager of the host area and the provider are mutually responsible for initiating the rate negotiation process. Negotiations may be conducted in a manner acceptable to both parties, but shall be conducted face to face upon the request of either party.

f. At the initiation of the rate negotiation process, the provider must disclose all relevant subcontractual and related-party relationships involved in the provision of foster group care services.

g. Negotiated rates shall not exceed any rate ceiling established or authorized by the legislature.

h. Once a negotiated rate is established, it shall not be changed or renegotiated, except in the following circumstances:

(1) Rates may be changed when funds are appropriated for an across-the-board increase. For the fiscal year beginning July 1, 2010, the reimbursement rates for foster group care service providers shall be increased by 1.31 percent over the rates in effect on June 30, 2010.

(2) Rates may be changed by mandated across-the-board decreases.

152.3(2) *New service.* When a prospective provider contracts to provide a foster group care service or an existing provider adds a new foster group care service on or after November 1, 2006, the rate for the new service shall be established based on a payment rate negotiated with the provider.

a. The starting point for negotiated rates shall be the weighted average for each service as of July 1, 1997, as previously established in accordance with 441—subrule 185.109(1), in effect at that time, and further calculated based on rule 441—156.9(234). These rates shall become the established weighted average rates for each service code as described in 441—Chapter 156 and in the appendices of the foster group care contract.

(1) The rate for community-level group care child welfare service is $8.43 per unit of service.

(2) The rate for community-level group care maintenance is $50.16 per unit of service.

(3) The rate for comprehensive-level group care child welfare service is $10.13 per unit of service.

(4) The rate for comprehensive-level group care maintenance is $60.31 per unit of service.

(5) The rate for enhanced comprehensive-level group care child welfare service is $13.36 per unit of service.

(6) The rate for enhanced comprehensive-level group care maintenance is $79.55 per unit of service.

b. In the event the department and a new provider or an existing provider adding a new foster group care service are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, a rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of a rate resolution process, no rate shall be established and the services in question shall not be part of any approved contract for foster group care services.

152.3(3) *Interruptions in a program.*

a. The rate for a new provider shall remain the same as the rate established for the former provider if:

(1) A provider assumes the delivery of a program from a related-party provider, or

(2) The difference between the former provider and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from partnership to corporation).

b. If a provider ceases to contract for and provide a foster group care service on or before October 31, 2006, and before the calculation of new rates according to rule 441—156.9(234), the rate in effect when the contract ceased shall be used to calculate the new rates to be used as the starting point in negotiations.

c. If a provider ceases to contract for and provide a foster group care service after a rate has been established in accordance with rule 441—156.9(234) and then decides to again contract for and provide the foster group care service, the rate shall be established at the rate in effect when the service was interrupted.

152.3(4) *Exception to rate policy.* When a provider not located in Iowa has been granted an exception to these rules based upon another state's requirement that its providers be paid the same rate they are paid for clients from that state, the exception shall continue in effect as written for the life of the contract.

152.3(5) *Across-the-board cuts.* Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8449B**, IAB 1/13/10, effective 1/1/10; **ARC 8652B**, IAB 4/7/10, effective 5/12/10; **ARC 8903B**, IAB 6/30/10, effective 7/1/10]

441—152.4(234) Initiation of contract proposal. All potential providers have a right to request a contract.

152.4(1) *Initial contact.* The initial contact shall be between the potential provider and the bureau of purchased services.

a. At the beginning of the contract development process, the bureau shall give the potential provider:

(1) Information about the contracting process; and

(2) Instructions on how to access the foster group care services provider handbook electronically.

b. The provider shall sign Form 470-3057, Verification of Receipt, at the end of the contract development process to verify receipt of information on how to access the handbook.

152.4(2) *Contract proposal development.* When the bureau of purchased services determines that a new contract is to be developed, a contract monitor shall be assigned to assist in contract development and processing. The contract monitor shall assist the applicant in the completion of the contract proposal and required fiscal information. The contract proposal shall include all of the following:

a. Form 470-3051, Foster Group Care Services Contract Face Sheet.

b. Form 470-3404, Foster Group Care Services Negotiated Rate Establishment Amendment. This form need not be completed until the completion of the rate negotiation process, but the contract proposal will not be acted upon until the form is completed and attached to the contract proposal.

c. Form 470-3052, Foster Group Care Services Contract, or Form 470-3053, Amendment to Foster Group Care Services Contract.

152.4(3) *Contract proposal approval.* The department shall review all complete proposed contracts for compliance with state and federal requirements.

a. The applicant shall submit four copies of the contract proposal to the assigned contract monitor 60 calendar days in advance of the desired effective date of the contract.

b. Submission within the time frame does not ensure the effective date of the contract. The department shall give the applicant notice and explanation in writing of any delay in the approval process.

c. The contract monitor shall forward four signed copies of the contract proposal to the bureau of purchased services within four weeks of receipt.

d. Before the contract can be effective, it shall be approved and signed by the following persons:

(1) An authorized representative of the provider.

(2) The service area manager, who shall make a decision within one week of receipt.

(3) The director of the department or the director's designee, who shall make a decision within 15 days of receipt.

152.4(4) *Rejection of contract proposal.* The department shall give the applicant notice and explanation in writing of the reasons for rejection of the contract proposal within ten working days of the decision. The following criteria may cause a proposed contract or proposed contract amendment to be rejected:

a. The proposed contract does not meet applicable rules, regulations, or guidelines.

b. The applicant has falsified any information required as a condition of participation.

c. Licenses submitted as a condition of participation in the contract process have never been approved or have been revoked or suspended.

d. The provider fails to provide notification within seven days of any changes that may significantly affect the licenses submitted as a condition of contracting.

e. The department and the provider fail to reach agreement on negotiated rates.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.5(234) Contract. All providers shall enter into a contract with the department using Form 470-3052, Foster Group Care Services Contract.

152.5(1) *Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of a new contract, a renewed contract, or an amendment to add a new service code to the contract is the day following signature of the director of the department or the director's designee, unless the provider and the department agree to a later specified date.

a. The contract shall be effective only after the provider is licensed to provide foster group care services as described in subrule 152.2(1).

b. The contract shall be effective only when signed by all parties as required by paragraph 152.4(3)*"d."*

152.5(2) *Liability for payment.* The department shall not be liable for payment for any programs or services before:

a. The contract effective date, or

b. The effective date of the rate for the program or service.

152.5(3) *Term of contract.* Pursuant to the provisions of 11—Chapters 106 and 107, the term of the contract is limited to no more than six years from the effective date of the contract.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.6(234) Client eligibility and referral.

152.6(1) *Determination of eligibility.* The department shall determine a child's eligibility for foster group care services. The department shall not make payment for foster group care services provided before the child's eligibility determination and service authorization.

152.6(2) *Court order.* If a child and family have been referred to the department and the department has not authorized foster group care services, but the services have been ordered by the juvenile court, the department shall make payment subject to availability of authorized funds.

152.6(3) *Service authorization.* Any change in the level of care or increase in the number of units or duration of foster group care services shall be authorized by the department.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.7(234) Billing procedures. At the end of each month, the provider shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided during the month for which the provider has documentation of the billed per diem services as described in subrule 152.2(6). Separate invoices shall be prepared for each county from which clients were referred. Each invoice shall contain claims for only one month of service. A separate invoice is required for each separate month of service if the service spans more than one month.

152.7(1) *Submission of invoices.* Complete invoices shall be sent to the department local office responsible for the client for approval and forwarding for payment. The time limit for submission of

original invoices shall be 90 days from the date of service, except at the end of the state fiscal year when claims for services through June 30 shall be submitted by August 10.

152.7(2) *Resubmittal of rejected claims.* Valid claims that were originally submitted within the time limit specified in subrule 152.7(1) but were rejected because of an error shall be resubmitted as soon as corrections are made.

152.7(3) *Payment.* The invoices shall be subject to audit and adjustment by the department. Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all claims concerning foster group care services rendered to clients.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.8(234) Contract management. During the contract period, the assigned contract monitor designated in the contract shall be the contract liaison between the department and the provider.

152.8(1) The provider shall contact the contract monitor about all interpretations and problems relating to the contract, and the contract monitor shall follow the issues through to their resolution.

152.8(2) The contract monitor shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance if needed. Form 470-0670, Report of On-Site Visit, shall be used to monitor performance under the contract.

152.8(3) The contract monitor shall make at least one on-site visit to each provider during the term of the provider's contract. The on-site visit shall be coordinated with on-site visits scheduled to fulfill requirements for provider reviews, licensing, or other on-site visits required by the department. Site visits to out-of-state providers shall be made at the discretion of the service area responsible for administration of the contract.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.9(234) Provider reviews. The department may review any provider at its discretion at any time. Records generated and maintained by the department or its fiscal agent may be used by reviewers and in all proceedings of the department.

152.9(1) *Review of provider records.* The department shall have the authority to conduct a scheduled or an unannounced site visit to evaluate the adequacy of service records in compliance with the policies and procedures for foster group care services.

152.9(2) *Purpose.* Upon proper identification, authorized representatives of the department shall have the right to review the service and fiscal records of the provider to determine whether:

a. The department has accurately paid claims for services.

b. The provider has furnished the services.

c. The provider has retained service records and fiscal records, as described in subrules 152.2(6) and 152.2(7), that substantiate claims submitted for payment during the review period.

d. Expenses reported to the department have been handled as required under subrule 152.2(8).

152.9(3) *Method.* The department shall select the appropriate method of conducting a review and shall protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Review procedures may include, but are not limited to, the following:

a. Comparing service and fiscal records with each claim.

b. Interviewing clients and employees of providers.

152.9(4) *Sampling.* The department's procedures for reviewing a provider's service records may include the use of random sampling and extrapolation. When these procedures are used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level.

a. *Findings.* The review findings generated through the review procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. *Extrapolation.* Findings of the sample will be extrapolated to the universe for the review period. The total of the payments determined to be in error in the review sample shall be divided by the total payments in the reviewed sample to calculate the percentage of dollars paid in error. This percentage

shall then be multiplied by the total payments in the review universe to determine the extrapolated overpayment.

c. *Disagreement with findings.* When the provider disagrees with the department's review findings and the findings have been generated through sampling and extrapolation, the provider may present evidence to show that the sample was invalid. The burden of proof of compliance rests with the provider. The evidence may include a 100 percent review of the universe of provider records used by the department in the drawing of the department's sample. This review shall:

(1) Be arranged and paid for by the provider.

(2) Be conducted by a certified public accountant.

(3) Demonstrate that bills and records not reviewed in the department's sample complied with program regulations and requirements.

(4) Be submitted to the department with all supporting documentation.

152.9(5) *Actions based on review findings.*

a. The department shall report the results of a review of provider records to concerned parties consistent with the provisions of 441—Chapter 9.

b. When an overpayment is found, the department may do one or more of the following:

(1) Request repayment in writing.

(2) Impose sanctions provided for in rule 441—152.10(234).

(3) Investigate and refer the matter to an agency empowered to prosecute.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.10(234) Sanctions against providers. Failure to meet the requirements relevant to provider contracting, financial record keeping, billing and payment, and client record keeping may subject providers to sanctions.

152.10(1) *Grounds for sanction.* The department may impose sanctions against a provider for committing one or more of the following actions:

a. Failing to provide and maintain the quality of the services to children and families within established standards, including:

(1) Failing to meet standards required by state or federal law for licensure.

(2) Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

(3) Engaging in a course of conduct or performing an act that is in violation of state or federal regulations or continuing that conduct following notification that it should cease.

(4) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions subject to this chapter.

(5) Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

(6) Being suspended or terminated from participation in another governmental program such as, but not limited to, workers' compensation or Medicaid remedial services.

(7) Committing a negligent practice resulting in client death or injury.

b. Failing to disclose or make available to the department or its authorized agent records of services provided to a child and family and records of payments made for those services.

c. Engaging in deceptive billing practices, such as:

(1) Presenting or causing to be presented for payment any false or deceptive claim for services.

(2) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

d. Submitting or causing to be submitted false information to meet service authorization requirements.

e. Inducing, furnishing or otherwise causing the child or family to receive foster group care services that are not authorized (overutilization of services).

f. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

g. Failing to repay or arrange for the repayment of identified overpayments or other erroneous payments.

152.10(2) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted.

a. Notification shall set forth:

(1) The nature of the discrepancies or violations.

(2) The known dollar value of the discrepancies or violations.

(3) The method of computing the dollar value.

(4) Further actions to be taken or sanctions to be imposed by the department.

(5) Any actions required of the provider.

b. The provider shall have 15 days after the date of the notice and before the department action to show cause why the action should not be taken.

152.10(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 152.10(1):

a. A term of probation for provision of foster group care services.

b. Termination from participation in the provision of foster group care services.

c. Suspension from provision of foster group care services.

d. Suspension or withholding of payments to the provider.

e. Review of 100 percent of the provider's claims before payment.

f. Referral to the appropriate state licensing board for investigation.

g. Referral of the matter to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of foster group care services licensure.

i. Termination of foster group care services licensure.

152.10(4) *Imposition and extent of sanction.* The department shall determine what sanction to impose. The following factors shall be considered in determining the sanction or sanctions to be imposed:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of technical assistance.

f. Pattern of failure to follow program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing bodies.

152.10(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider. Each decision to include an affiliate shall be made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated when the conduct was committed in the course of official duty or was effectuated with the knowledge or approval of that person.

b. When there are grounds for sanction pursuant to subrule 152.10(1) against a provider facility, campus, or site, the department may suspend or terminate the provision of foster group care services by:

(1) The provider; or

(2) The specific facility, campus, or site; or

(3) Any individual within the provider's organization who is responsible for the violation.

c. No provider shall submit claims for payments to the department for any services provided by any facility, campus, site, or person within the organization that has been suspended or terminated from provision of foster group care services except for those services provided before the suspension or termination.

d. Suspension or termination from provision of foster group care services shall preclude the submission of claims to the department for payment for any services provided after suspension or termination, whether submitted personally or through the provider.

152.10(6) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to paragraph 152.9(5)*"b"* or subrule 152.10(2) and has demanded repayment of an identified overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

152.10(7) *Notice of sanction.* When a provider has been sanctioned, the department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—152.11(234) Appeals of departmental actions. Providers may appeal decisions of the department, other than rate determinations, according to rules in 441—Chapter 7.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

"Department" means the Iowa department of human services.

"Director" means the director of the child support recovery unit of the department or the director's designee.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Mental retardation professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the

educational requirements for the profession, as required in the state of Iowa, and has one year of experience working with persons with mental retardation.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Service area manager" means the department employee or designee responsible for managing department offices within a department service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care which require additional skill, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

"Unearned income" means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$15.74
6 through 11	$16.37
12 through 15	$17.92
16 or over	$18.16

156.6(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.6(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.6(4) *Difficulty of care payment.*

a. For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus $5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

b. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

c. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

d. Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

e. Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, mental health professional, or mental retardation professional, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

f. For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.44 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

156.6(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.6(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38 and 2010 Iowa Acts, House File 2526, section 33(4), and House File 2531, section 83(5).

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8904B**, IAB 6/30/10, effective 7/1/10]

441—156.7(234) Purchase of family foster care services. Rescinded IAB 5/6/09, effective 7/1/09.

441—156.8(234) Additional payments.

156.8(1) *Clothing allowance.* When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed $237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed $190 for family foster care and $100 for all other levels when:

(1) The child needs clothing to replace lost clothing or because of growth or weight change, and

(2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.8(2) *Supervised apartment living.* When a youth is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $400 if the youth does not have sufficient resources to cover initial costs.

156.8(3) *Medical care.* When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

156.8(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid

program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.8(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.8(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed $5 may be authorized by the department worker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or a mental retardation professional has recommended school attendance.

156.8(7) *Respite care.* The service area manager or designee may authorize respite for a child in family foster care for up to 24 days per calendar year per placement. Respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—156.9(234) Rate of payment for foster group care.

156.9(1) *In-state reimbursement.* Effective November 1, 2006, public and private foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with the rate-setting methodology in this subrule.

a. A provider of group care services shall maintain at least the minimum staff-to-child ratio during prime programming time as established in the contract. Staff shall meet minimum qualifications as established in 441—Chapters 114 and 115. The actual number and qualifications of the staff will vary depending on the needs of the children.

b. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

c. Reimbursement rates shall be adjusted based on the provider's rate in effect on October 31, 2006, to reflect an estimate that group care providers will provide an average of one hour per day of group remedial services and one hour per week of individual remedial services. The reimbursement rate shall be calculated as follows:

(1) Step 1. Annualize the provider's combined daily reimbursement rate for maintenance and service in effect on October 31, 2006, by multiplying that combined rate by 365 days.

(2) Step 2. Annualize the provider's remedial services reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

(3) Step 3. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

(4) Step 4. Add the amounts determined in Steps 2 and 3.

(5) Step 5. Subtract the amount determined in Step 4 from the amount determined in Step 1.

(6) Step 6. Divide the amount determined in Step 5 by 365 to compute the new combined maintenance and child welfare service per diem rate.

(7) Step 7. Determine the maintenance portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 85.62 percent.

(8) Step 8. Determine the child welfare service portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 14.38 percent.

EXAMPLE: Provider A has the following rates as of October 31, 2006:

- A combined daily maintenance and service rate of $121.45;
- A Medicaid rate for service code 96153 of $5.10 per 15 minutes, or $20.40 per hour;
- A Medicaid rate for service code 96152 of $19.92 per 15 minutes, or $79.68 per hour.

Step 1. $121.45 × 365 days = $44,329.25
Step 2. $20.40 × 365 days = $7,446.00
Step 3. $79.68 × 52 weeks = $4,143.36
Step 4. $7,446.00 + $4,143.36 = $11,589.36
Step 5. $44,329.25 - $11,589.36 = $32,739.89
Step 6. $32,739.89 ÷ 365 days = $89.70
Step 7. $89.70 × 0.8562 = $76.80 maintenance rate
Step 8. $89.70 × 0.1438 = $12.90 child welfare service rate

Provider A's rates are $76.80 for maintenance and $12.90 for child welfare services.

d. No less than annually, the department shall redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions based on review of verified remedial services cost reports for foster group care services providers. If the new allocation differs from the current allocation, the department shall:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates and the effective date.

156.9(2) *Out-of-state group care payment rate.* The payment rate for maintenance and child welfare services provided by public or private agency group care licensed or approved in another state shall be established using the same rate-setting methodology as that in subrule 156.9(1), unless the director determines that appropriate care is not available within the state pursuant to the following criteria and procedures.

a. *Criteria.* When determining whether appropriate care is available within the state, the director shall consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service fund or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. *Procedure.* The service area manager or chief juvenile court officer shall submit the request for director's exception to the Bureau of Policy Analysis, Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in 156.9(2)*"a."*

c. *Appeals.* The decision of the director regarding approval of an exception to the rate determination in rule 441—152.3(234) is not appealable.

156.9(3) *Supplemental payments for in-state facilities.* Rescinded IAB 9/1/93, effective 8/12/93.

156.9(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, the maintenance rate for the mother shall include an additional amount to cover the actual and allowable maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

a. The rate shall be determined according to the policies in rule 441—152.3(234) and added to the maintenance rate for the mother. The young child portion of the maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

b. Rescinded IAB 6/8/94, effective 6/1/94.

c. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

d. The facility shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or general education equivalent (GED).

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

e. The agency shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a GED program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

f. The agency shall designate $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8715B**, IAB 5/5/10, effective 7/1/10]

441—156.10(234) Payment for reserve bed days.

156.10(1) *Group care facilities.* The department shall provide payment for group care maintenance and child welfare services according to the following policies.

a. *Family visits.* Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the worker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility shall be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. *Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. *Runaways.* Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.

(3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. *Preplacement visits.* Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.10(2) *Foster family care.*

a. *Family visits.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

b. *Hospitalization.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. *Runaways.* Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home shall be for the child to return to the foster family home.

(3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(4) Payment shall not exceed two consecutive days.

156.10(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.11(234) Emergency care.

156.11(1) and **156.11(2)** Rescinded IAB 3/11/09, effective 5/1/09.

156.11(3) Shelter care payment. Public and private juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the rate-setting methodology in 441—paragraph 150.3(5)*"p."*

a. Facilities shall bill for actual units of service provided in accordance with 441—subrule 150.3(8). In addition, facilities may be guaranteed a minimum level of payment to the extent determined by the department through a request-for-proposal process.

(1) Guaranteed payment shall be calculated monthly.

(2) The guaranteed level of payment shall be calculated by multiplying the number of beds for which payment is guaranteed by the number of days in the month.

(3) When the actual unit billings for a facility do not equal the guaranteed level of payment for the month, the facility may submit a supplemental billing for the deficiency.

(4) The amount of the supplemental billing shall be determined by multiplying the facility's unit cost for shelter care by the number of units below the guaranteed level for the month for which the facility was not reimbursed.

b. The total reimbursement to the agency shall not exceed the agency's allowable costs as defined in 441—subrule 150.3(5). Agencies shall refund any payments which have been made in excess of the agencies' allowable costs.

c. Shelter contracts for the state fiscal year beginning July 1, 2007, shall provide for the statewide availability of a daily average of 273 guaranteed emergency juvenile shelter care beds during the fiscal year.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09]

441—156.12(234) Supervised apartment living.

156.12(1) *Maintenance.* When a youth at least aged 16 but under the age of 20 is living in a supervised apartment living situation, the maximum monthly maintenance payment for the youth shall be $573.90. This payment may be paid to the youth or another payee, other than a department employee, for the youth's care.

156.12(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—156.13(234) Excessive rates. Rescinded IAB 6/9/93, effective 8/1/93.

441—156.14(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

441—156.15(234) Child's earnings. Earned income of a child who is not in a supervised apartment living arrangement and who is a full-time student or engaged in an educational or training program shall be reported to the department and its use shall be a part of a plan for service, but the income shall not be used towards the cost of the child's care as established by the department. When the earned income of children in supervised apartment living arrangements or of other children exceeds the foster care standard, the income in excess of the standard shall be applied to meet the cost of the child's care. When the income of the child exceeds twice the cost of maintenance, the child shall be discontinued from foster care.

441—156.16(234) Trust funds and investments.

156.16(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

156.16(2) The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

156.16(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.17(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.18(237) Foster parent training expenses. Rescinded IAB 7/29/09, effective 10/1/09.

441—156.19(237) Rate of payment for care in a residential care facility. When a child is receiving group care maintenance and child welfare services in a licensed residential care facility and is not eligible for supplemental security income or state supplementary assistance, the department will pay for the group care maintenance and child welfare services in accordance with subrule 156.9(1). When a child receives group care maintenance and child welfare services in a licensed residential care facility and is eligible for supplemental security income or state supplementary assistance, the department will pay for child welfare services in accordance with subrule 156.9(1).

This rule is intended to implement Iowa Code section 237.1(3)*"e."*

441—156.20(234) Eligibility for foster care payment.

156.20(1) *Client eligibility.* Foster care payment shall be limited to the following populations.

a. Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52, subsection 2, paragraph *"d,"* Iowa Code section 232.102, subsection 1, Iowa Code section 232.117, or Iowa Code section 232.182, subsection 5.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20, subsection 1, or Iowa Code section 232.21.

3. The department has agreed to provide foster care pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements which have been authorized by the department and which conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria. The child's eligibility for the exception shall be documented in the case record.

1. The child does not have mental retardation. Funding for services for persons with mental retardation is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds which may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area's funding allocation shall be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in subrule 156.6(4), paragraph *"a,"* and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.20(2) *Provider eligibility for payment.*

a. Providers of shelter care services and supervised apartment living services shall have a purchase of service contract under 441—Chapter 150 in force.

b. Providers of group care services shall have a foster group care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

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CHAPTER 177
IN-HOME HEALTH RELATED CARE

[Prior to 7/1/83, Social Services[770] Ch 148]
[Previously appeared as Ch 148—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services [498]]

441—177.1(249) In-home health related care. In-home health related care is a program of nursing care in an individual's own home to provide personal services to an individual because such individual's state of physical or mental health prevents independent self-care.

441—177.2(249) Own home. Own home means an individual's house, apartment, or other living arrangement intended for single or family residential use.

441—177.3(249) Service criteria. The client shall require health care services that would require the supervision of a professional registered nurse working under the certification of a physician.

177.3(1) Skilled services may include but not be limited to:

a. Gavage feedings of individuals unable to eat solid foods.

b. Intravenous therapy administered only by a registered nurse.

c. Intramuscular injections required more than once or twice a week, excluding diabetes.

d. Catheterizations, continuing care of indwelling catheters with supervision of irrigations and changing of Foley catheter when required.

e. Inhalation therapy.

f. Care of decubiti and other ulcerated areas, noting and reporting to physician.

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

h. Tracheotomy care.

i. Colostomy care until the individual is capable of maintaining the colostomy personally.

j. Care of medical conditions out of control which includes brittle diabetes and terminal conditions.

k. Postsurgical nursing care, but only for short time periods, and primarily for individuals with complications following surgery, or with the need for frequent dressing changes.

l. Monitoring medications needed for close supervision of medications because of fluctuating physical or psychological conditions, i.e., hypertensives, digitalis preparations, narcotics.

m. Diets which are therapeutic and require evaluation at frequent intervals.

n. Vital signs which is the recording and reporting of change in vital signs to the attending physician.

177.3(2) Personal care services may include but not be limited to:

a. Supervision on a 24-hour basis for physical or emotional needs.

b. Helping client with bath, shampoo, oral hygiene.

c. Helping client with toileting.

d. Helping client in and out of bed and with ambulation.

e. Helping client to reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by the physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization.

441—177.4(249) Eligibility.

177.4(1) *Eligible individual.*

a. The individual shall be eligible for supplemental security income in every respect except for income.

b. The physician's certification shall include a statement of the specific health care services and that the services can be provided in the individual's own home. The certification shall be given on Form 470-0673, Physician's Report, or on a similar plan of care form presently used by public health agencies.

c. The individual shall live in the individual's own home.

d. The client shall require and be receiving qualified health care services. Qualified health care services are health care services supervised by a registered nurse and approved by a physician.

177.4(2) *Relationship to other programs.* In-home health related care shall be provided only when other existing programs cannot meet the client's need.

177.4(3) *Maximum costs.* The maximum cost of service shall be $480.55. The provider shall accept the payment made and shall make no additional charges to the recipient or others.

177.4(4) *Service plan.* A complete service plan shall be prepared which includes the services needed, the plan for providing these services, and the health care plan defined in rule 177.6(249).

177.4(5) *Certification procedure.* The approval of the case plan by the service area manager or designee shall constitute certification and approval for payment.

177.4(6) *Temporary absence from home.* The client will remain eligible and payment will be made for services for a period not to exceed 15 days in any calendar month when the client is absent from the home for a temporary period. Payment will not be authorized for over 15 days for any continuous absence whether or not the absence extends into a succeeding month or months.

177.4(7) *Income for adults.* The countable income of the individual and spouse living in the home shall be limited to $480.55 per month if one needs care or $961.10 if both need care, after the following disregards from gross income:

a. The amount of the basic supplemental security income standard for an individual or a couple, as applicable.

b. When income is earned, $65.00 plus one-half of any remaining income.

c. The amount of the supplemental security income standard for a dependent plus any established unmet medical needs, for each dependent living in the home. Any income of the dependent shall be applied to the dependent's needs before making this disregard.

d. The amount of the established medical needs of the ineligible spouse which are not otherwise met.

e. The amount of the established medical needs of the applicant or recipient which are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

f. Rescinded, effective 7/1/84.

177.4(8) *Income for children.*

a. All income received by the parents in the home shall be deemed to the child with the following disregards:

(1) The amount of the basic supplemental security income standard for an individual when there is one parent in the home or for a couple when there are two parents in the home.

(2) The amount of the basic supplemental security income standard for a dependent for each ineligible child in the home.

(3) The amount of the unmet medical needs of the parents and ineligible dependents.

(4) When all income is earned, an additional basic supplemental security income standard for an individual in a one-parent home or for a couple in a two-parent home.

(5) When the income is both earned and unearned, $65.00 plus one-half of the remainder of the earned income.

b. The countable income of the child shall be limited to $480.55 per month after the following disregards from gross income:

(1) The amount of the basic supplemental security income standard for an individual.

(2) The amount of the established medical needs of the child which are not otherwise met and would not be met if the child were eligible for the medical assistance program.

(3) One-third of the child support payments received from an absent parent.

c. Rescinded, effective 7/1/84.

177.4(9) *Payment.* The client or the person legally designated to handle the client's finances shall be the sole payee for payments made under the program and shall be responsible for making payment to the provider except when the client payee becomes incapacitated or dies while receiving service.

a. The department shall have the authority to issue one payment to a provider on behalf of a client payee who becomes incapacitated or dies while receiving service.

b. When continuation of an incapacitated client payee in the program is appropriate, the department shall assist the client and the client's family to legally designate a person to handle the client's finances. Guardians, conservators, protective or representative payees, or persons holding power of attorney are considered to be legally designated.

c. Payment for the program shall be approved effective as of the date of application or the date all eligibility requirements are met and qualified health care services are provided, whichever is later, notwithstanding 42 U.S.C. 1382(c)(7).

177.4(10) *Application.* Application for in-home health-related care shall be made on Form 470-2927 or 470-2927(S), Health Services Application. An eligibility determination shall be completed within 30 days from the date of the application, unless one or more of the following conditions exist:

a. An application has been filed and is pending for federal supplemental security income benefits.

b. The application is pending because the department has not received information, which is beyond the control of the client or the department.

c. The application is pending due to the disability determination process performed through the department.

d. The application is pending because Form 470-0636, Provider Agreement, has not been completed and completion is beyond control of the client. When Form 470-0636 cannot be completed due to the client's failure to locate a provider, applications shall not be held pending beyond 60 days from the date of application.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09]

441—177.5(249) Providers of health care services.

177.5(1) *Age.* The provider shall be at least 18 years of age.

177.5(2) *Health assessment.* The provider shall obtain certification that the provider is physically and emotionally capable of providing assistance to another person who may have physical and emotional limitations.

a. The certification shall be based on an examination performed by a physician or advanced registered nurse practitioner or by a physician assistant who is working under the direction of a physician. If the provider works for an agency, the practitioner performing the examination may not be employed by the same agency.

b. The practitioner conducting the examination shall indicate the certification by signing Form 470-0672, Provider Health Assessment.

c. The certification shall be submitted to the department service worker:

(1) Before the provider agreement is signed, and

(2) Annually thereafter.

177.5(3) *Qualifications.* The provider shall be qualified by training and experience to carry out the health care plan as specified in rule 177.4(4).

177.5(4) *Relative.* The provider may be related to the client, so long as the provider is not a member of the family as defined in rule 441—130.1(234).

[**ARC 8912B**, IAB 6/30/10, effective 9/1/10]

441—177.6(249) Health care plan. The nurse shall complete the health care plan with the physician's approval. The health care plan shall include the specific types of services required, the method of providing those services, and the expected duration of services.

177.6(1) *Transfer from medical facility.* When the client is being transferred from a medical hospital or long-term care facility, the service worker shall obtain a transfer document describing the client's current care plan, to be provided to the nurse supervising the in-home care plan.

177.6(2) *Medical records.*

a. Medical records shall include, whenever appropriate, transfer forms, physician's certification and orders, interdisciplinary case plan, interdisciplinary progress notes, drug administration records, treatment records, and incident reports. The nurse shall be responsible for ensuring that record requirements are met.

b. Medical records shall be located in the nurse's case file, with a copy of the interdisciplinary plan of care and physician's plan of service in the service worker's file, and all other records available to the service worker. Upon termination of the in-home care plan, the records shall be maintained in the county office of the department of human services, or in the office of the public health nurse and available to the service worker, for five years or until completion of an audit.

c. The client or legal representative shall have the right to view the client's medical records.

177.6(3) *Review.* The continuing need for in-home health care services shall be reviewed:

a. At a minimum of every 60 days by the physician, including a written recertification of continuing appropriateness of the plan;

b. At a minimum of every six months by the service worker, including a review of the total care plan;

c. At a minimum of every 60 days by the nurse who shall review the nursing plan; or

d. More frequently if required by the physician, the service worker, or the nurse.

177.6(4) *Annual physical.* The client shall obtain a physical examination report annually and shall be under the regular supervision of a physician.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09]

441—177.7(249) Client participation.

177.7(1) All income remaining after the disregards in 177.4(7) and 177.4(8) shall be considered income available for services and shall be used for service costs before payment for in-home health care begins.

177.7(2) First month. When the first month of service is less than a full month, there is no client participation for that month. Payment will be made for the actual days of service provided according to the agreed-upon rate.

441—177.8(249) Determination of reasonable charges. Payment will be made only for reasonable charges for in-home health care services as determined by the service worker. Reasonableness shall be determined by:

177.8(1) *Community standards.* The prevailing community standards for cost of care for similar services.

177.8(2) *Services at no charge.* The availability of service providers at no cost to the department.

441—177.9(249) Written agreements.

177.9(1) *Independent contractor.* The provider shall be an independent contractor and shall in no sense be an agent, employee or servant of the state of Iowa, the Iowa department of human services, any of its employees, or of its clients.

177.9(2) *Liability coverage.* All professional health care providers shall have adequate liability coverage consistent with their responsibilities, as the department of human services assumes no responsibility for, or liability for, individuals providing care.

177.9(3) *Provider agreement.* The client and the provider shall enter into an agreement, using Form 470-0636, Provider Agreement, prior to the provision of service. Any reduction to the state supplemental assistance program shall be applied to the maximum amount paid by the department of human services as stated in the Provider Agreement by using Form 470-1999, Amendment to Provider Agreement.

441—177.10(249) Emergency services. Written instructions for dealing with emergency situations shall be completed by the nurse and maintained in the client's home and in the county department of human services office. The instructions shall include:

177.10(1) *Persons to notify.* The name and telephone number of the client's physician, the nurse, responsible family members or other significant persons, and the service worker.

177.10(2) *Hospital.* Information as to which hospital to utilize.

177.10(3) *Ambulance.* Information as to which ambulance service or other emergency transportation to utilize.

441—177.11(249) Termination. Termination of in-home health related care shall occur under the following conditions.

177.11(1) *Request.* Upon the request of the client or legal representative.

177.11(2) *Care unnecessary.* When the client becomes sufficiently self-sustaining to remain in the client's own home with services that can be provided by existing community agencies as determined by the service worker.

177.11(3) *Additional care necessary.* When the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

177.11(4) *Excessive costs.* When the cost of care exceeds the maximum established in 177.4(3).

177.11(5) *Other services utilized.* When the service worker determines that other services can be utilized to better meet the client's needs.

177.11(6) *Terms of provider agreement not met.* When it has been determined by the service worker that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

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These rules are intended to implement Iowa Code section 249.3(2)*"a"*(2).

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CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

PREAMBLE

This chapter implemented a five-year demonstration waiver project for a subsidized guardianship program to provide financial assistance to guardians of eligible children who are not able to be adopted and who are not able to return home. Notification has been given to the United States Department of Health and Human Services that the demonstration project will end effective September 1, 2010. A subsidized guardianship agreement authorized under this chapter will remain in effect until the agreement is terminated under the terms of this chapter.
[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.1(234) Definitions.

"Child" means a person who has not attained the age of 18.

"Department" means the Iowa department of human services.

"Guardianship subsidy" means a monthly payment to assist in covering the cost of room, board, clothing, and spending money for the child.

"Nonrecurring expenses" means reasonable and necessary guardianship fees, court costs, attorney fees, and other expenses that are directly related to finalizing the legal guardianship of a child. These expenses shall be limited to attorney fees, court filing fees and other court costs.

"Sibling group" means at least two children who are whole or half-siblings. A sibling group may include adopted children who have a common parent. Stepsiblings are not included as part of the sibling group.

441—204.2(234) Eligibility.

204.2(1) *General conditions of eligibility.* The guardian named in a permanency order under Iowa Code section 232.104(2)*"d"*(1) or Iowa Code chapter 633 for a child who was previously in the custody of the department is eligible for subsidy when all of the following conditions exist:

a. The child has a documented permanency goal of:

(1) Long-term foster care;

(2) Guardianship; or

(3) Another planned permanent living arrangement.

b. The child has been in a licensed foster care placement and has lived in foster care for at least 6 of the last 12 months.

c. The child is either:

(1) 14 years of age or older and consents to the guardianship; or

(2) 12 years of age or older and guardianship has been determined to be in the child's best interest; or

(3) Under 12 years of age and part of a sibling group with a child aged 12 or older.

d. The child has lived in continuous placement with the prospective guardian for the six months before initiation of the guardianship subsidy.

e. The guardian is a person who has a significant relationship with the child and demonstrates a willingness to make a long-term commitment to the child's care.

(1) The guardian may be a relative or nonrelative,

(2) Placement with that guardian must be in the best interest of the child. The best-interest determination must be documented in the case file.

f. The child has been randomly selected to participate in the waiver demonstration project.

204.2(2) *Residency.* The subsidized guardianship applicant or recipient need not reside in Iowa.

204.2(3) *Unearned income.* The family or the guardian shall provide to the department worker documentation from the source of the child's unearned income.

204.2(4) *Other services.* Rescinded IAB 10/11/06, effective 11/1/06.

441—204.3(234) Application. Applications for the subsidized guardianship program shall not be accepted after August 31, 2010.
[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.4(234) Negotiation of amount of subsidy.

204.4(1) *Subsidy agreement.* The amount of subsidy shall be negotiated between the department and the guardian, and shall be based upon the needs of the child, and the circumstances of the family. Each time negotiations are completed, the Guardianship Subsidy Agreement, Form 470-3631, shall be completed and signed by the guardian and the department worker.

204.4(2) *Amount of subsidy.* The department shall enter into the agreement based upon available funds. Each time negotiations are completed, the department worker and guardian shall complete Form 470-3631, Guardianship Subsidy Agreement.

a. The guardianship subsidy shall be based on a flat daily foster care rate adjusted according to the needs of the child and the circumstances of the family.

(1) The rate for the guardianship subsidy shall not exceed the state's current daily basic foster care rate plus any daily level 1 or 2 special needs allowance or sibling allowance for which the child is eligible, as found at 441—subrule 156.6(1) and 441—paragraphs 156.6(4)*"b"* and *"f."*

(2) Rescinded IAB 1/3/07, effective 1/1/07.

b. If the payment is less than the maximum amount allowed, the guardian may request an increase if the child's or family's needs and circumstances require additional resources.

204.4(3) *Placement outside of home.* If a child needs to be placed out of the guardian's home and the plan is for the child to return to the guardian within six months, a partial subsidy amount may be negotiated.

204.4(4) *Nonrecurring expenses.* The nonrecurring expenses necessary to finalize a guardianship shall be limited to the amount found in 441—subparagraph 201.6(1)*"a"*(7).

441—204.5(234) Parental liability. These subsidy payments are considered foster care payments for purposes of child support recovery and as such create a support debt for the parents.

441—204.6(234) Termination of subsidy. A guardianship subsidy agreement negotiated based on an application signed on or before August 31, 2010, shall remain in effect until the subsidy is terminated based on one of the grounds listed in this rule. The subsidy shall terminate when any of the following occur, and a notice shall be sent which states the reason for the termination:

1. The child reaches the age of 18, unless the department determines that the subsidy may continue until the child reaches the age of 19 to facilitate the child's completion of high school or a high school equivalency diploma.
2. The child marries or enlists in the military.
3. The child no longer lives with the guardian, except for placement outside the home as limited by subrule 204.4(3).
4. The relationship ends due to the death of the child or the death of the guardian of the child (one in a single-parent family or both in a two-parent family).
5. The terms of Form 470-3631, Guardianship Subsidy Agreement, are concluded.
6. The guardian requests that the guardianship payment cease.
7. Due to incapacity, the guardian can no longer discharge the responsibilities necessary to protect and care for the child, and the guardianship has been or will be vacated.
8. The guardian fails to abide by the terms of Form 470-3631, Guardianship Subsidy Agreement.
9. The guardianship case is terminated by court order.
10. The department funds for subsidized guardianship are no longer available.

[**ARC 8914B**, IAB 6/30/10, effective 8/4/10]

441—204.7(234) Reinstatement of subsidy. Reinstatement of the subsidy shall be made when the subsidy was terminated because of the guardian's request, and the guardian has requested reinstatement.

441—204.8(234) Appeals. The guardian may appeal adverse determination pursuant to 441—Chapter 7.

441—204.9(234) Medical assistance. Children eligible for subsidy are entitled to medical assistance as defined in 441—Chapter 75. When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the guardian.

The funding source for medical assistance is based on the following criteria:

1. Children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

2. Children from Iowa residing in another state shall receive medical assistance from the state of residence if eligible. Iowa shall provide medical assistance for children not eligible in their state of residence. Medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

3. Children from another state residing in Iowa shall continue to be covered by the other state's medical assistance unless the state has adopted the adoption assistance interstate compact and a contract between Iowa and the other state exists.

These rules are intended to implement Iowa Code section 234.6 and 2006 Iowa Acts, House File 2734, section 17, subsection 10.

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NATURAL RESOURCE COMMISSION[571]

[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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[Prior to 12/31/86, Conservation Commission[290]]

571—23.1(483A) Purpose and definitions. The purpose of this rule is to designate procedures for allotments of wildlife habitat stamp revenues to local entities. These funds must be used specifically for the acquisition of whole or partial interests in land from willing sellers for use as wildlife habitats, and the development and enhancement of wildlife lands and habitat areas. The department of natural resources will administer the stamp funds for the purposes as stated in the law at both the state and local levels. The following definitions apply in these rules:

"Commission" means the natural resource commission.

"Department" means the department of natural resources.

"Director" means the director of the department or a designee.

"Waiver of retroactivity" means approval by the department for an applicant to purchase land prior to the next round of wildlife habitat fund application reviews. The waiver allows the applicant to remain eligible for the next round of wildlife habitat funds when extenuating circumstances exist that require an immediate purchase of the subject property by the applicant or a third party that will hold the property until funds become available to the applicant.

[**ARC 8885B**, IAB 6/30/10, effective 8/18/10]

571—23.2(483A) Availability of funds. Habitat stamp funds are dependent on stamp sales. The amount of moneys available at any time will be determined by revenues received by the department. Final stamp sales for each calendar year will be determined by July 1 of the following year.

23.2(1) *Local share.* Funds available for local entities shall be specified in the department's budget in accordance with legislative appropriations. At least 50 percent of the stamp revenues will be apportioned to local entities. Funds will be made available during a fiscal year of July 1 to June 30.

23.2(2) *Distribution.* After deducting 5 percent to be held for contingencies, the remaining local share will be available on a semiannual basis each year.

571—23.3(483A) Eligibility. Only those public agencies authorized by law to spend funds for wildlife habitat shall be eligible to participate in this program.

571—23.4(483A) Project limitations. Because of administrative costs, no application for assistance totaling less than $3,000 (total project cost—$4,000) will be considered.

571—23.5(483A) Eligibility for cost-sharing assistance. No project shall be eligible for cost sharing unless it is specifically approved by the commission, or the applicant has received a written waiver of retroactivity from the director, prior to its initiation. A project shall not be eligible for cost sharing unless public hunting and trapping will be allowed; however, the review and selection committee may recommend for commission approval projects with restrictions on hunting and trapping under exceptional circumstances, such as waterfowl refuges. Fees charged for recreational purposes will not be allowed on land purchased or developed with wildlife habitat funds. Wildlife habitat promotion funds shall not be used to fund mitigation lands or banks, or other lands, to satisfy mitigation requirements. Only the following types of project expenditures will be eligible for cost-sharing assistance.

23.5(1) *Acquisition projects.* Lands or rights thereto to be acquired in fee or by any other instrument shall be appraised by a competent appraiser and the appraisal approved by the department staff. Applicants whose applications have been approved for funding must submit an appraisal that meets the Uniform Appraisal Standards for Federal Land Acquisitions. The appraisal requirements may be waived when the staff determines that they are impractical for a specific project. Cost sharing will not be approved for more than 75 percent of the approved appraised value. Acquisition projects are eligible for either cost sharing by direct payments as described in subrule 23.12(7) or by reimbursement to local entities.

When a county receives or will receive financial income directly or indirectly from sources that would have been paid to the previous landowner as a result of a purchase agreement or other title transfer action, 75 percent of that income will be transferred to the department unless the grantee has demonstrated and committed to habitat development projects or additional acquisitions on the project site to be funded from the income received. The project review and selection committee must recommend, and the director and commission must approve, plans for the expenditure of income. In the absence of acceptable wildlife habitat development or acquisition plans, the county will transfer 75 percent of income received to the department as it is received. The department will credit that income to the county apportionment of the wildlife habitat stamp fund as described in subrule 23.2(1). The schedule of those reimbursements from a county to the state will be included in the project agreement.

23.5(2) *Development projects.* Eligible expenditures for development projects shall include seeding and planting of habitat to support or enhance the wildlife area. Requests to purchase equipment will not be approved. Donated labor, materials and equipment use, and force account labor and equipment use shall not be eligible for cost-sharing assistance. (Force account means the agency's own labor and equipment use.) Development projects are limited to lands legally controlled by the grantee for the expected life of the project. Development projects are eligible only for reimbursement of reasonable costs actually incurred and paid by the public agency.

23.5(3) *Enhancement projects.* For purposes of this rule, "enhancement" shall be considered to be synonymous with "development."

This rule is intended to implement the provisions of Iowa Code section 483A.3.

[**ARC 8885B**, IAB 6/30/10, effective 8/18/10]

571—23.6(483A) Application for assistance. Applications shall provide sufficient detail as to clearly describe the scope of the project and how the area will be managed.

23.6(1) *Form.* Applications shall be submitted on forms provided by the department.

23.6(2) *Time of submission.* Applications for funds shall be reviewed and selected for funding during January and July of each year. Applications must be received in acceptable form by the Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319, by the close of business on the last business day of May for consideration at the summer review and the last business day of November for the winter review. Changes to grant applications must be submitted to the department no later than 4 p.m. the day prior to the committee review date. Upon timely notice to eligible recipients, additional selection periods may be scheduled if necessary to expedite the distribution of these funds. In emergencies, local entities can obtain a waiver so that acquisition projects may be approved for retroactive payments, provided that funds are available and the project meets all other criteria.

23.6(3) *Local funding.* By signing the application, the applicant agency is certifying that all required match has been identified and is committed and available for the project. An applicant shall certify in writing that it has the 25 percent match committed and available, by signing on the signature block provided on the form, and shall state the means of providing for the local share. All necessary approvals for acquisition and financing shall be included with the application. All financial income received directly or indirectly from sources that would have been paid to the previous landowner as a result of a purchase agreement or other title transfer action will be completely documented in the application.

23.6(4) *Development projects.* An application for development project assistance may include development on more than one area if the development is of a like nature (e.g., planting trees and shrubs).

This rule is intended to implement the provisions of Iowa Code section 483A.3.

[**ARC 8885B**, IAB 6/30/10, effective 8/18/10]

571—23.7(483A) Project review and selection.

23.7(1) *Review and selection committee.* A review and selection committee, hereinafter referred to as the committee, composed of one person appointed by the director to represent the department and designated by the director as chairperson and four persons appointed by the director to represent county conservation boards shall determine which grant applications and amendment requests shall be selected for funding.

23.7(2) *Consideration withheld.* The committee will not consider any application which, on the date of the selection session, is not complete, or for which additional pertinent information has been requested and not received.

23.7(3) *Application rating system.* The committee will apply a numerical rating system to each grant application which is considered for fund assistance. The following criteria, with a weight factor for each, will be considered:

Wildlife habitat needs	2
Existing or potential habitat quality	3
Cost-effectiveness	1 if at least 35 percent less than appraised amount 2 if at least 45 percent less than appraised amount
Species diversity	1

Each criterion will be given a score of from 0 to 10 which is then multiplied by the weight factor. Three additional criteria will be considered in the rating system:

a. *Prior assistance.* Any applicant who has never received a prior grant for acquisition of land will be given a bonus of 5 points.

b. *Active projects.* Any applicant who has one or more active projects at the time of application rating will be assessed 5 penalty points for each one that has not been completed by the date specified in the project agreement. A project is deemed closed after the project has had a final inspection, all funds have been paid and, in the case of acquisition, the title has been transferred from the seller.

c. *Urgency.* Projects may be given 1 or 2 bonus points if there is a strong urgency to acquire lands which might otherwise be lost.

All points will be totaled for each application, and those applications receiving the highest scores will be selected for fund assistance to the extent of the allotment for each semiannual period, except that any project scoring a total of not more than 45 points will not be funded.

23.7(4) *Applications not selected for fund assistance.* All applications not selected for fund assistance will be retained on file for consideration and possible funding during subsequent review periods or until a request for withdrawal is received from the applicant. Applications which have been considered and not selected for funding during three consecutive review periods will be returned to the applicant.

23.7(5) *Rating system not used.* The rating system will not be applied during any semiannual period in which the total grant request, including backlogged applications, is less than the allotment. Applications will be reviewed only to determine eligibility and overall desirability, and to ascertain that they meet minimum scoring requirements.

23.7(6) *Rating of scores for tie breakers.* If two or more projects receive the same score, the committee shall use the points awarded to existing or potential habitat quality to determine which project has a higher rank. If after considering the existing or potential habitat quality points the project scores remain tied, the committee will then consider the points awarded for species diversity. If after considering the species diversity points the project scores remain tied, the committee will then consider the points awarded for wildlife habitat needs.

[**ARC 8885B**, IAB 6/30/10, effective 8/18/10]

571—23.8(483A) Commission review. The natural resource commission will review and act upon all committee recommendations semiannually at the next following commission meeting. The commission may reject any application selected for funding.

571—23.9(483A) Grant amendments. Projects for which grants have been approved may be amended, if funds are available, to increase or decrease project scope or to increase or decrease project costs and fund assistance. Project changes must be approved by the director prior to their inception. Amendments to increase project costs and fund assistance due to cost overruns will not be approved where funds have already been committed or the work already performed.

571—23.10(483A) Timely commencement of projects. Grant recipients are expected to carry out their projects in an expeditious manner. Projects for which grants are approved shall be commenced within six months of the date upon which the grantee is notified that the project is approved, or at another date agreed upon by both parties. Failure to do so may be cause for termination of the project and cancellation of the grant by the commission.

571—23.11(483A) Project period. A project period which is commensurate with the work to be accomplished will be assigned to each project. Project period extensions will be granted only in a case of extenuating circumstances.

571—23.12(483A) Payments.

23.12(1) *Grant amount.* Grant recipients will be paid 75 percent of all eligible costs incurred on a project up to the amount of the grant unless otherwise specified in the project agreement.

23.12(2) *Project billings.* Grant recipients shall submit billings for reimbursements or cost-sharing on forms provided by the commission.

23.12(3) *Project billing frequency.* Project billings for development shall be submitted on the following basis:

a. Up to $10,000 total project cost—one billing.

b. Over $10,000 total project cost—no more than two billings.

23.12(4) *Final project billing.* A final project billing shall be submitted within 90 days following the end of a project period. Failure to do so may be cause for termination of the project with no further reimbursement to the grant recipient.

23.12(5) *Documentation.* Grant recipients shall provide documentation as required by the department to substantiate all costs incurred on a project.

23.12(6) *Reimbursement withheld.* Ten percent of the total reimbursement due any grant recipient for a development project will be withheld pending a final site inspection or until any irregularities discovered as a result of a final inspection have been resolved.

23.12(7) *Acquisition projects.* If clearly requested in the project application and the applicant has shown good cause for such procedure, the department may approve direct payment to the seller of the state's share provided that marketable fee simple title, free and clear of all liens and encumbrances or material objections, is obtained by the local entity at the time of payments and state funds are then available.

23.12(8) *Development projects.* On approved development projects, payment will be made by the state only as reimbursement for funds already expended by the local entity.

571—23.13(483A) Record keeping and retention. A grant recipient shall keep adequate records relating to its administration of a project, particularly relating to all incurred costs and direct or indirect income from other sources that normally would have been paid to the previous landowner resulting from a purchase agreement or other title transfer action. A copy of the county's audits particularly showing such income and disbursements for the grant period will be submitted to the department of natural resources' budget and grants bureau. These records shall be available for audit by appropriate personnel of the department and the state auditor's office. All records shall be retained in accordance with state laws.

571—23.14(483A) Penalties. Whenever any property, real or personal, acquired or developed with habitat stamp fund assistance passes from the control of the grantee or is used for other purposes which conflict with the project purpose, it will be considered an unlawful use of the funds. The department shall notify the local entity of any such violation.

23.14(1) *Remedy.* Funds thus used unlawfully must be returned to the department for inclusion in the wildlife habitat stamp fund, or a property of equal value at current market prices and with commensurate benefits to wildlife must be acquired with local, non-cost-shared funds to replace it. Such replacement must be approved by the commission. The local entity shall have a period of two years after notification

by the department in which to correct the unlawful use of funds. The remedies provided by this rule are in addition to others provided by law.

23.14(2) *Land disposal.* Whenever it has been determined and agreed upon by the grantee and the commission that land acquired or developed with habitat stamp fund assistance is no longer of value for the project purpose, or that the local entity has other good cause, the land, with the approval of the commission, may be disposed of and the proceeds thereof used to acquire or develop an area of equal value, or 75 percent of the proceeds shall be returned to the state for inclusion in the wildlife habitat stamp fund.

23.14(3) *Ineligibility.* Whenever a local agency shall be in violation of this rule, it shall be ineligible for further assistance until the matter has been resolved to the satisfaction of the commission.

[**ARC 8885B**, IAB 6/30/10, effective 8/18/10]

These rules are intended to implement Iowa Code section 483A.3.

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[1] Effective date of rule 23.1(7/31/91) delayed until adjournment of the 1992 Session of the General Assembly by the Administrative Rules Review Committee (ARRC) at its meeting held July 12, 1991. Delay lifted at the ARRC meeting held November 13, 1991.

CHAPTER 40
BOATING SPEED AND DISTANCE ZONING
[Prior to 12/31/86, Conservation Commission[290] Ch 30]

571—40.1(462A) Restricted areas. All vessels, except authorized emergency vessels, shall be operated in compliance with, and all persons engaged in water recreation activities, shall obey restrictions with posted areas marked with a uniform waterway buoy or official signs adopted by the natural resource commission.

571—40.2(462A) Uniform buoy system. All buoys placed shall be those of the uniform waterway marking system adopted by the natural resource commission and shall be constructed, placed, and maintained in accordance with Iowa Code chapter 462A and Iowa Administrative Code 571—Chapters 40 and 41.

571—40.3(462A) Commission approval. The placement of buoys or official signs that restrict speed and distance or involve special zoning restrictions shall be approved by the natural resource commission.

571—40.4(462A) Right for aggrieved party to appeal. Any finding or establishment of areas involving special speed and distance or zoning restrictions by the natural resource commission may be appealed by aggrieved party upon written notice. A hearing thereon shall be held by the natural resource commission within 30 days thereafter.

571—40.5(462A) Rathbun Lake, Appanoose County—zoned areas.

40.5(1) Areas may be specifically designated for swimming and wading.

40.5(2) Areas may be designated restricted speed areas.

571—40.6(462A) Red Rock Lake, Marion County—zoned areas.

40.6(1) Areas may be specifically designated for swimming and wading.

40.6(2) Areas may be designated restricted speed areas.

40.6(3) Areas may be designated as “no anchoring” areas.

571—40.7(462A) Coralville Lake, Johnson County—zoned areas.

40.7(1) Areas may be specifically designated for swimming and wading.

40.7(2) Areas may be designated restricted speed areas.

571—40.8(462A) Saylorville Lake, Polk County—zoned areas.

40.8(1) Areas may be specifically designated for swimming and wading.

40.8(2) Areas may be designated restricted speed areas.

571—40.9(462A) Lake Odessa in Louisa County.

40.9(1) Areas may be designated restricted speed areas.

40.9(2) All motorboats, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour year around, on that portion of Lake Odessa known as the Sand Run Chute, lying south of the main lake to a point 100 yards south of the Sand Run Chute boat ramp.

40.9(3) All motorboats, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour year around, on those portions of Lake Odessa known as the lateral ditch, between the main lake and Bebee Pond, and on the channel between Yankee Chute and Beaver Pond.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.10(462A) Mississippi River lock and dam safety zone. A safety zone is hereby established in Iowa waters above and below all navigation lock and dam structures on the Mississippi River between the Iowa-Minnesota border and the Iowa-Missouri border. The established zone shall be 600 feet upstream and 150 feet downstream from the roller gate or tainter gate section of the structure.

40.10(1) The safety zone does not include the area directly above and below the navigation lock structure.

40.10(2) The safety zone does not include the area directly above and below the solid fill portion of the dam and structure.

40.10(3) The safety zone shall be recognized by the state of Iowa only when plainly marked as follows:

a. Upstream signs worded—Restricted area keep 600 feet from dam.

b. Downstream signs worded—Restricted area keep 150 feet from dam.

c. Flashing red lights will be used to make the outer limits of the restricted areas.

40.10(4) No boat or vessel of any type, except authorized vessels, shall enter the established safety zones recognized by the state of Iowa as described in this rule.

571—40.11(462A) Joyce Slough Area. The Joyce Slough Area, a portion of the Mississippi River within the city of Clinton, Iowa, is hereby zoned to be a harbor area and vessels traveling therein shall not travel at speeds in excess of five miles per hour.

571—40.12(462A) Swan Slough, Camanche, Iowa. A restricted speed zone of not greater than 5 miles per hour is hereby established in all or part of the main channel of Swan Slough (Mississippi River mile 510.2 to 511.3), Camanche, Iowa, as designated by buoys.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.13(462A) Massey Slough. The operation of vessels in Massey Slough of the Mississippi River at Massey Station, Dubuque County, Iowa, extending from a northerly to southerly direction from the upper end to the lower end of the slough, encompassing the water in Section 14, Township 88N, Range 3E of the 5th P.M., tract number NFIA-26M, is restricted as follows:

40.13(1) All boats underway must maintain a speed of less than five miles per hour in said waters.

40.13(2) Reserved.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.14(462A) Black Hawk County waters. Operation of vessels in Black Hawk County on the Cedar River and any connected backwaters shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.14(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys, signs, or other approved uniform waterway marking devices marking the area.

40.14(2) All vessels, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour when within 600 feet of the Franklin Street bridge. This 600-foot zone shall be designated by buoys, signs, or other approved uniform waterway marking devices.

40.14(3) No vessel shall tow skiers, surfboard riders, or other towable devices within the zone established by 40.14(2).
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.15(462A) Mitchell County waters. Operation of vessels in Mitchell County is restricted to speeds not greater than 5 miles per hour where a speed zone is designated by buoys on the following impounded waters:

Cedar River from Mitchell Dam, thence upriver to the County "S" bridge.

Cedar River from the St. Ansgar Mill Dam, thence upriver to the Newberg Bridge crossing Highway 105.

Cedar River from the Otranto Dam upriver to the Great Western Railway Bridge crossing the Cedar River.

The Stacyville Pool, on the Little Cedar River at Stacyville, Iowa.

40.15(1) Water recreation activities as restricted within posted areas which are marked with approved buoys shall be obeyed.

40.15(2) Reserved.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.16(462A) Maquoketa River. Operation of vessels of the impoundment of the Maquoketa River in Delaware County, Iowa, extending westerly and northerly from the line between Sections 29 and 30 in Delhi Township in said county, to the line between Sections 10 and 15 in Milo Township in said county which impoundment is sometimes known and referred to as Hartwick Lake or Lake Delhi.

40.16(1) Water recreation activity restrictions shall be obeyed, including restrictions within posted areas which are marked with approved buoys.

40.16(2) No motorboat shall be operated at speeds greater than ten miles per hour at any time between the hours from one hour after sunset to one hour before sunrise.

571—40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County. No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area designated by regulatory buoys or signs on the off-channel waters of the Wapsipinicon River above the dam at Central City, Linn County, Iowa.

The zoned area will be the off-channel waters created in and adjacent to the developed recreation areas of the Pinicon Ridge Park on the west and south bank of the Wapsipinicon River above the dam at Central City, Linn County.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.18(462A) Speed restrictions on Lake Manawa. No motorboat shall be operated at a speed greater than five miles per hour within the zoned areas 300 feet from shore around Lake Manawa in Pottawattamie County.

571—40.19(462A) Zoning of Little Wall Lake. No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area designated by regulatory buoys on Little Wall Lake in Hamilton County.

The zoned area will not exceed approximately 20 acres in the northeast portion of the lake identified by a line from a point on the high-water mark approximately 296.6 feet west of the southeast corner of the southwest quarter of Section 10, Township 86 North, Range 24 West; thence northwest to the high-water mark which is 775 feet south and 319 feet west of the northeast corner of the northwest quarter of the southwest quarter of Section 10, Township 86 North, Range 24 West.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.20(462A) Lake Icaria, Adams County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Lake Icaria. The following rules shall govern vessel operation on Lake Icaria in Adams County.

40.20(1) All vessels shall be operated at a speed not greater than 5 miles per hour when within 50 feet of another vessel which is not underway or is operating at a no-wake speed.

40.20(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys or signs in accordance with 571—Chapter 41.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. Said buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by uniform marker buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50 feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.21(462A) Zoning of the Des Moines River. Vessel operation on the Des Moines River from its confluence with the Mississippi River in Lee County to the northerly meander lines of both the East and West Branches, shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.21(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys marking said areas.

40.21(2) No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys.

571—40.22(462A) Upper Gar Lake, Dickinson County. Operation of vessels on Upper Gar Lake is restricted to a speed not greater than 5 miles per hour between the Henshaw Bridge at the north end of Upper Gar and south end of East Lake and the Old Sawmill Bridge at the south end of Upper Gar and the north end of Minnewashta.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.23(462A) Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County.

40.23(1) All vessels operated between the ice dike and Bussey Lake access shall be operated at a speed not greater than 5 miles per hour.

40.23(2) The city will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.24(462A) Mt. Ayr City Lake (Loch Ayr). A motorboat shall not be operated within 100 feet of shore at a speed greater than 5 miles per hour.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.25(462A) Iowa River in Iowa City, Johnson County. No person shall operate any vessel towing persons on water skis, surfboards, or similar devices on the Iowa River in the area bounded by the Coralville Mill Dam and the Burlington Street Dam, except during regattas, races, marine parades, tournaments, or exhibitions authorized by the natural resource commission to be held in such area.

571—40.26(462A) Zoning of the Mississippi River, Dubuque, Dubuque County.

40.26(1) All vessels shall be limited to no more than five miles per hour in Lake Peosta Cut south and east of the Hawthorn Street municipal boat launching ramp.

40.26(2) A restricted speed zone of no more than 5 miles per hour is established in the vicinity of Chaplain Schmitt Memorial Island in proximity to the Schmitt Island municipal launching ramp and in waters adjacent to the southerly shoreline in the area of the Dubuque Yacht Basin.

40.26(3) A restricted speed zone of five miles per hour for the northern portion of Shawondassee Slough. Marker buoys shall be placed at a point approximately 750 feet upstream from the existing speed zone.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.27(462A) Zoning Harpers Slough, Harpers Ferry, Allamakee County.

40.27(1) All vessels operated in Harpers Slough between a point 200 feet above the state ramp and 200 feet out from the west shore extending downstream to a point known as Sandy Point Road Dead-End shall operate at a speed not greater than 5 miles per hour.

40.27(2) The city of Harpers Ferry will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.28(462A) Black Hawk Lake, Sac County—zoned areas.

40.28(1) No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area marked by the regulatory buoys. The zoned area shall be the area commonly known as Town Bay on the northwest corner of Black Hawk Lake in Sac County.

40.28(2) Areas may be specifically designated for swimming by the use of regulatory buoys.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.29(462A) Speed and other restrictions on Brown's Lake, Woodbury County. All vessels shall be operated at a speed not greater than 5 miles per hour within the two zoned areas designated by regulatory buoys or other approved uniform waterway markers.

40.29(1) *Zone 1.* Zone 1 shall extend 570 yards from the boat ramp east to the regulatory buoys and 150 yards west from the boat ramp.

40.29(2) *Zone 2.* Zone 2 shall begin at the regulatory buoys located at the 24-inch steel pipe and shall extend west.

40.29(3) *Swimming.* Areas may be specifically designated for swimming by the use of regulatory buoys.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.30(462A) Speed and other restrictions on Snyder Bend Lake, Woodbury County. All vessels shall be operated at a speed not greater than 5 miles per hour within the zoned area 400 yards from the boat ramp south to the regulatory sign and buoys.

Areas may be specifically designated for swimming by the use of regulatory buoys.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.31(462A) Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County. No motorboat shall be operated at a speed greater than 5 miles per hour within the three zoned areas designated by regulatory buoys on East Okoboji and West Okoboji Lakes in Dickinson County.

40.31(1) Zone 1. Zone 1 shall be a line from the east side of Givens Point to the south end of Arnolds Park City Beach on West Okoboji. Also, a line 150 yards east from the north end of the railroad trestle bridge at Clair Wilson State Park south to the shoreline of East Okoboji.

40.31(2) Zone 2. Zone 2 shall be the area which is 300 feet north of the area commonly known as the Narrows on East Okoboji and 200 feet south of the area commonly known as the Narrows on East Okoboji.

40.31(3) Zone 3. Zone 3 shall be the area 50 feet east of the bridge between East Okoboji and Upper Gar on the East Okoboji side running in a northwesterly direction toward the end of the island from Gingles Point then west toward the shoreline.

40.31(4) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.31(5) The following areas are zoned 5 miles per hour on West Okoboji.

a. Zone 1. Zone 1 shall be the area commonly known as Okoboji Harbor at the northwest corner of West Okoboji.

b. Zone 2. Zone 2 shall be the area commonly known as the canals in the city of Wahpeton including Turtle Lake.

c. Zone 3. Zone 3 shall be the area commonly known as Lazy Lagoon located in the Triboji Area on West Okoboji.

d. Zone 4. Zone 4 shall be the area commonly known as Little Millers Bay. The zone shall start at Pinkies Point and extend southeasterly (160 degrees) approximately 370 yards until bisecting the southern shoreline of Little Millers Bay.

e. Zone 5. Zone 5 shall be the area commonly known as Little Emmerson Bay. The zone shall start at Breezy Point and extend southwesterly (235 degrees) approximately 330 yards until bisecting the west shoreline of Little Emmerson Bay.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.32(462A) Spirit Lake, Dickinson County—zoned areas.

40.32(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.32(2) The following areas are zoned 5 miles per hour on Spirit Lake, Dickinson County:

a. Zone 1 shall be the area commonly known as Templar Park Lagoon located midlake on the west shore of Spirit Lake.

b. Reserved.

571—40.33(462A) Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park. No motorboat shall operate at a speed to exceed 5 miles per hour within the area designated by buoys or other approved uniform waterway markers, beginning at the entrance of Spruce Creek harbor and extending southeast 550 feet and extending east 150 feet from shore. The Jackson County conservation board will designate the speed zone with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.34(462A) Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula. No motorboat shall operate at a speed to exceed five miles per hour within the four zoned areas designated by buoys or other approved uniform waterway markers.

40.34(1) *Zone 1.* Zone 1 shall extend 200 feet from shore and begin at a point 250 feet upstream of the north Sabula city boat ramp and ending at a point downstream where Bank Street intersects the river bank.

40.34(2) *Zone 2.* Zone 2 shall extend 200 feet from shore and extend 100 feet upstream and 100 feet downstream from the entrance to the Island City Harbor.

40.34(3) *Zone 3.* Zone 3 shall extend 200 feet into South Sabula Lake from the county boat ramp and 100 feet to the west of the ramp and 600 feet to the east of the ramp.

40.34(4) *Zone 4.* Zone 4 shall extend 200 feet in all directions beginning at the center of the "cut" into Lower Sabula Lake.

The city of Sabula shall designate the speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.35(462A) Speed restrictions on the Greene Impoundment of the Shell Rock River. No motorboat shall be operated at a speed exceeding five miles per hour in the two zoned areas of the Greene Impoundment designated by buoys or other approved uniform waterway markers. The first zoned area extends from the dam in the city of Greene, upstream approximately one-quarter mile to the north boundary of the city park in which the lower boat ramp is located. The second zoned area extends from the county bridge over the Shell Rock River on the north side of section 28 of Union Township in Floyd County, downstream approximately one-quarter mile to the south boundary of Gates Bridge County Park. The city of Greene and Floyd County shall designate their respective speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.36(462A) Zoning of the Iowa River, Iowa Falls, Hardin County.

40.36(1) All vessels operated in a designated zone between the River Street Bridge and the dock at Dougan's Landing shall be operated at a speed not greater than 5 miles per hour.

40.36(2) The city of Iowa Falls shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.37(462A) Zoning of Crystal Lake. No motorboat shall be operated at a speed greater than 5 miles per hour within the 25-acre zoned area designated by regulatory buoys on Crystal Lake in Hancock County.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.38(462A) Five Island Lake, Palo Alto County.

40.38(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.38(2) Reserved.

571—40.39(462A) Lost Island Lake, Palo Alto and Clay Counties.

40.39(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.39(2) Reserved.

571—40.40(462A) Ingham Lake, Emmet County.

40.40(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.40(2) Reserved.

571—40.41(462A) Storm Lake, Buena Vista County.

40.41(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.41(2) Reserved.

571—40.42(462A) Raccoon River Regional Park Lake, Polk County.

40.42(1) All vessels shall be operated at a speed not greater than 5 miles per hour.

40.42(2) A 40-acre body of water located in the southeast corner, and separate from the main lake, shall be designated for nonmotorized and electric motors only. The city of West Des Moines will designate the area with regulatory buoys and signs.

40.42(3) Areas may be specifically designated for swimming by the use of regulatory buoys.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.43(462A) Zoning of the Mississippi River, Bellevue, Jackson County.

40.43(1) All vessels shall be operated at a speed not greater than 5 miles per hour within the area designated by buoys or other approved uniform waterway markers beginning at the mouth of Mill Creek and extending upstream 900 feet, and extending 200 feet perpendicular from shore. The area shall be designated by a minimum of four approved buoys to be uniformly placed along the 900-foot length of the zone parallel to the shore.

40.43(2) The city of Bellevue will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.44(462A) Three Mile Lake, Union County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Three Mile Lake. The following rules shall govern vessel operation on Three Mile Lake in Union County.

40.44(1) All vessels shall be operated at a speed not greater than 5 miles per hour when within 50 feet of another vessel which is not underway or is operating at a speed not greater than 5 miles per hour.

40.44(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by use of regulatory buoys in accordance with Iowa Administrative Code 571—Chapter 41. The Union County conservation board shall designate and maintain a swimming area(s) by the use of regulatory buoys approved by the natural resource commission.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. No motorboats, except authorized emergency vessels, shall be operated other than at a speed not greater than 5 miles per hour above a line of buoys placed across the lake at the point where County Road H33 intersects the lake. All buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by regulatory buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50 feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.

[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.45(462A) Zoning of the Cedar River.

40.45(1) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending east 150 feet from the intersection of Wabash Street and Charles City Road and north 380 feet shall be operated at a speed not greater than 5 miles per hour. The city of Nashua shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

40.45(2) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending north 131 feet from the intersection of Wabash Street and the north entrance to Cedar View Circle and east 80 feet and west 80 feet from this point along the shoreline and extending 110 feet north into the lake shall be operated at a speed not greater than 5 miles per hour. The city of Nashua shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

40.45(3) *Charles City, Floyd County.* All vessels operated in a designated zone extending 300 feet upstream from the upper dam shall be operated at a speed not greater than five miles per hour. The city of Charles City shall designate and maintain the five miles per hour speed zone with marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.46(462A) Zoning of Carter Lake, Pottawattamie County.

40.46(1) All vessels operated in a designated zone known as Shoal Pointe Canal shall be operated at a speed not greater than 5 miles per hour.

40.46(2) The city of Carter Lake shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.47(462A) Zoning of the Mississippi River, McGregor, Clayton County.

40.47(1) All vessels, except commercial barge traffic, shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 634 and 633.4 and designated by buoys or other approved uniform waterway markers.

40.47(2) The city of McGregor will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.48(462A) Zoning of the Mississippi River, Marquette, Clayton County.

40.48(1) All vessels, except commercial barge traffic, shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 634.5 and 634.9 and designated by buoys or other approved uniform waterway markers.

40.48(2) The city of Marquette will designate and maintain the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.49(462A) Zoning of Green Island, Jackson County. All motorboats except authorized emergency vessels shall be operated at a speed no greater than 5 miles per hour year around on boat channels adjacent to the interior channel 4 levee at the Green Island State Wildlife area. Both channels begin at the Green Island county road parking lot and proceed north 7920 feet along each side of the channel 4 levee to an intersection with the Snag Slough complex.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.50(462A) Mooring of vessels on riparian property of the state of Iowa. Where the state of Iowa owns riparian property adjacent to sovereign land or water, mooring of vessels is prohibited between sunset and sunrise on those riparian or sovereign lands or waters where posted by either official buoys or official signs of the department of natural resources.

571—40.51(462A) Little River Lake, Decatur County. Motorboats of outboard or inboard-outdrive type shall be permitted on Little River Lake. Vessels operating within a designated area beginning at the dam and extending north approximately to the mouth of "Bait Shop Bay" shall be operated at a speed no greater than 5 miles per hour. The Decatur County conservation board shall designate the speed zone with marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.52(462A) Zoning of the Mississippi River, Johnson Slough, Clayton County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 627

and 629.8, in a backwater known as Johnson Slough and designated by marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.53(462A) Zoning of the Mississippi River, Mud Lake, Dubuque County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 587.6 to 589.3, in a backwater known as Mud Lake and designated by marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.54(462A) Nighttime speed limit, Dickinson County. No vessels, except authorized emergency vessels, shall be operated at speeds greater than 25 miles per hour at any time between one-half hour after sunset and sunrise on all lakes located in Dickinson County.

571—40.55(462A) Zoning of Clear Lake, Cerro Gordo County.

40.55(1) Areas may be specifically designated for swimming with the use of regulatory buoys.

40.55(2) Areas within close proximity of dredging operations may be designated as areas where the speed of vessels is restricted to not greater than 5 miles per hour.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.56(462A) Zoning of Mississippi River, Des Moines County, city of Burlington. All vessels shall be operated at a speed no greater than five miles per hour within the area designated by marker buoys or other approved uniform waterway markers beginning at the north city boat ramp and public dock and extending downstream to the south city boat ramp and public dock. The zoned area shall extend no farther than 150 feet from the shore and approximately 150 feet west of the west edge of the barge channel. The city of Burlington shall designate the five-mile-per-hour speed zone with buoys approved by the natural resource commission.
[**ARC 7532B**, IAB 1/28/09, effective 3/6/09]

571—40.57(462A) Zoning of Catfish Creek, Mines of Spain State Recreation Area, Dubuque County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area beginning at the mouth of Catfish Creek and extending upstream to the confluence of Catfish Creek and Granger Creek and designated by uniform marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.58(462A) Zoning of Lake Cornelia, Wright County. All vessels shall be operated at a speed not greater than 5 miles per hour in the boat harbor and at the boat harbor entrance within the zoned area extending 300 feet from two points on shore and 100 feet in width, equidistant from either side of the harbor entrance. The Wright County conservation board shall designate the boat harbor entrance and the public swimming area with uniform marker buoys approved by the natural resource commission.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

571—40.59(462A) Zoning of lakes in Dickinson County. All vessels shall be operated at a speed not greater than 5 miles per hour within 300 feet of shore on all lakes in Dickinson County.
[**ARC 8877B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement the provisions of Iowa Code sections 462A.17, 462A.26, and 462A.31.

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◊ Two or more ARCs

CHAPTER 44
SPECIAL EVENTS

[Prior to 12/31/86, Conservation Commission[290] Ch 35]

571—44.1(321G,321I,462A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Administrative processing fee" means the fee collected for the processing of each special event application that is submitted for specific vessel, snow, and all-terrain vehicle events.

"All-terrain vehicle" or *"ATV"* means a motorized flotation-tire vehicle with not less than three and not more than six low-pressure tires that is limited in engine displacement to less than 1,000 cubic centimeters and in total dry weight to less than 1,000 pounds and that has a seat or saddle designed to be straddled by the operator and handlebars for steering control.

"Centralized special events application system" means the Web-based system used by applicants to submit applications for activities related to regulated vehicles and vessels which are permitted under this chapter. Approved applications shall be placed on a calendar of events Web page, accessible from the department's homepage, to inform the general public of scheduled events on public land, ice, and water.

"Commission" means the natural resource commission.

"Demonstration" means an outward display showing how equipment works or items are used, with or without the intent to sell; a meeting, gathering, or parade; or a competitive event, tournament, or race.

"Department" means the Iowa department of natural resources.

"Exhibition" means the act or fact of exhibiting items or equipment; or a public show or display of items or equipment.

"Off-road motorcycle" means a two-wheeled motor vehicle that has a seat or saddle designed to be straddled by the operator and handlebars for steering control and that is intended by the manufacturer for use on natural terrain. "Off-road motorcycle" includes a motorcycle that was originally issued a certificate of title and registered for highway use under Iowa Code chapter 321 but which contains design features that enable operation over natural terrain.

"Off-road utility vehicle" means a motorized flotation-tire vehicle with not less than four and not more than eight low-pressure tires that is limited in engine displacement to less than 1,500 cubic centimeters and in total dry weight to not more than 1,800 pounds and that has a seat that is of bucket or bench design, not intended to be straddled by the operator, and a steering wheel or control levers for control. A motorized vehicle that was previously titled or is currently titled under Iowa Code chapter 321 shall not be registered or operated as an off-road utility vehicle.

"Permit" means a document issued by the department that enumerates all stipulations, requirements, and contingencies that the applicant must accept and adhere to throughout the duration of the approved event.

"Program coordinator" means the person assigned from the snowmobile, all-terrain vehicle, and boating programs to coordinate the processing of special event applications and who serves as the primary contact for information about special events for the respective programs.

"Snowmobile" means a motorized vehicle weighing less than 1,000 pounds which uses sled-type runners or skis, endless belt-type tread with a width of 48 inches or less, or any combination of runners, skis, or tread and which is designed for travel on snow or ice. "Snowmobile" does not include an all-terrain vehicle, as defined in Iowa Code section 321I.1, which has been altered or equipped with runners, skis, belt-type tracks, or treads.

"Special event" means an organized race, tournament, exhibition, or demonstration of limited duration that is conducted on public land, ice, or waters of the state under the jurisdiction of the commission according to a prearranged schedule and in which general public interest is manifested.

"Vessel" means every description of watercraft, other than a seaplane, used or capable of being used as a means of transportation on water or ice. Ice boats are considered watercraft.

[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.2(321G,321I,462A) Applicability. These rules are applicable to all fee title and dedicated lands and all waters under the jurisdiction of the commission or those lands and waters managed by the commission for public access.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.3(321G,321I,462A) Permit required. A permit issued by the department is required in order to conduct a special event as defined in this chapter on public land, ice, or waters under the jurisdiction of the natural resource commission, including dealer demonstrations. Any one of the following criteria may determine the need for a special event permit:

1. The event is open to the public.
2. The event charges an admission fee.
3. The event awards prizes.
4. The event promotes competitive events.
5. Attendance is solicited through advertising, invitation, or other solicitation.
6. The event may adversely impact the use of the area by others.

[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.4(321G,321I,462A) Permit conditions. The department may impose conditions not specifically covered herein for any special event as deemed necessary to protect the resource or to ensure public safety. Such conditions shall be included in the permit issued by the department.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.5(321G,321I,462A) Application procedures. The following procedures shall be used when applying for a special event permit:

44.5(1) Application shall be made on an electronic form accessed through the department's centralized special events application system.

44.5(2) The application shall be received electronically by the department via the centralized special events application system.

44.5(3) Applications shall be accepted beginning January 1 of a given year for requested tournament dates extending to March 1 of the following year and shall not be accepted later than 30 days prior to the requested date for tournaments.

44.5(4) The number of events to be held at any area on the same day may be restricted if deemed necessary to avoid congestion within the area so as to protect the resource. The commission shall consider the capacity of facilities such as boat ramps, docks, parking lots, and other area facilities and features when processing applications.

44.5(5) Permits are nontransferable.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.6(321G,321I,462A) Alternate dates. Alternate dates for the event may be submitted by the applicant. The department may approve a submitted alternate date for the event. If an alternate date is approved, the primary date shall still be used unless unforeseen circumstances prevent its use. If an alternate date must be used for the event, the applicant shall contact the program coordinator at least one week in advance of the date on which the event shall take place to obtain final approval to use the alternate date. The program coordinator shall document this approval in writing. Upon approval of an alternate date, the applicant shall notify the local conservation officer, and the program coordinator shall update the calendar of events.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.7(321G,321I,462A) Insurance coverage. The applicant shall secure event liability insurance and shall name the department as an additional insured. Insurance information shall be available at the time the application is submitted. The applicant shall have a copy of the insurance policy available at the event location to present to department personnel if requested.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.8(321G,321I,462A) Fees. The administrative fee for processing each special event application is $25. The fee is nonrefundable.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.9(321G,321I,462A) Buildings or structures placed on ice during a special event. The following criteria apply to the placement, construction, or erection of structures placed on ice during a special event.

44.9(1) *Vendor information provided on application.* The applicant shall identify the names and addresses of any vendors who will be on site during the special event.

44.9(2) *Owner information.* The full name, street address, and city of the building or structure owner shall be displayed legibly in a color contrasting to the background on all sides of the building or structure in block letters at least four inches in height.

44.9(3) *Accessibility.* Buildings or structures shall not be locked when in use.

44.9(4) *Reflectors.* Buildings or structures shall have reflectors attached to all sides of the building or structure in such a manner to enable them to reflect light at all times from sunrise to sunset.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.10(462A) Boating special events—registration exemptions. Vessels entered in special events shall not be required to be registered as stated in Iowa Code sections 462A.4 and 462A.5, subject to the following regulations.

44.10(1) *Vessel and participant list.* Sponsors of the special event shall maintain a list of the names and addresses of all persons participating in the event and a description of each vessel in the event.

44.10(2) *Vessels identified.* Each vessel in the special event shall be labeled with an identifying number or letter, which shall be clearly visible and which shall be recorded with the names and addresses of vessel passengers on the list as provided for in subrule 44.10(1).

44.10(3) *Exemption period.* Any vessel entered into a special event may be exempted from state registration requirements for the full 24-hour period of each day covered by the permit to conduct such event and as issued under Iowa Code section 462A.16.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.11(462A) Mississippi River or Missouri River. A department special event application is not needed for fireworks or boating events on the Mississippi River or Missouri River upon notification and proof that a United States Coast Guard (U.S.C.G.) permit has been secured. The regional U.S.C.G. office issuing permits for Mississippi and Missouri River events is located in St. Louis, Missouri.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.12(321G,321I,462A) Other Iowa Code provisions and permits. The applicant for a special event permit is responsible for ensuring full compliance with regulations of Iowa Code chapters 321G, 321I, and 462A and any other Iowa Code chapters and rules promulgated under those chapters that may be applicable for an event. Likewise, an applicant is required to acquire and comply with all applicable state and local permits issued by other state and local agencies necessary to hold the special event.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.13(321G,321I,462A) Authority to cancel or stop an event. At any time that a conservation officer, park manager, or park ranger determines that a special event is not in compliance with the permit issued or that safety concerns warrant canceling or stopping the event, the conservation officer, park manager, or park ranger has the authority to do so.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.14(321G,321I,462A) Future special event permits. The issuance of future permits to an applicant is contingent upon the applicant's compliance with past permits.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.15(321G,321I,462A) Nonexclusive use of area. Issuance of a special event permit does not grant the applicant exclusive use of the land, water, or ice that is the subject of the permit unless the permit explicitly authorizes exclusive use.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

571—44.16(321G,321I,462A) Other special events. These rules do not apply to special events that are governed exclusively by the department's parks bureau, fisheries bureau, or wildlife bureau, except to the extent that the authorization given under this chapter to use a concession in a state park fulfills the parks bureau's special event concession requirements in 571—Chapter 61.
[**ARC 8815B**, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter)]

These rules are intended to implement Iowa Code sections 321G.2, 321I.2, and 462A.16.

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[1] July 7, 2010, effective date of ARC 8815B delayed for 70 days by the Administrative Rules Review Committee at its meeting held June 8, 2010.

CHAPTER 46
ALL-TERRAIN VEHICLES, OFF-ROAD MOTORCYCLES AND OFF-ROAD UTILITY VEHICLES

DIVISION I
REGISTRATION, RENEWAL, TITLING, DECAL PLACEMENT AND ACCIDENT REPORTS

571—46.1(321I) Definitions. For purposes of this chapter, the following definitions shall apply:

"All-terrain vehicle" means a motorized flotation-tire vehicle with not less than three and not more than six low-pressure tires that is limited in engine displacement to less than 1,000 cubic centimeters and in total dry weight to less than 1,000 pounds and that has a seat or saddle designed to be straddled by the operator and handlebars for steering control.

"A scale" means the physical scale marked "A" and graduated in decibels on a sound level meter which meets the requirements of the American National Standards Institute, Incorporated, publication S1.4-1983, General Purpose Sound Level Meters.

"Commission" means the natural resource commission established in Iowa Code section 455A.5.

"Department" means the department of natural resources established in Iowa Code section 455A.2.

"Designated riding area" means an off-highway vehicle riding area on any public land or ice under the jurisdiction of the department that has been designated by the commission under Iowa Code chapter 321I for such use.

"Designated riding trail" means an off-highway vehicle riding trail on any public land or ice under the jurisdiction of the department that has been designated by the department for all-terrain vehicle use.

"Off-road motorcycle" means a two-wheeled motor vehicle that has a seat or saddle designed to be straddled by the operator and handlebars for steering control and that is intended by the manufacturer for use on natural terrain. "Off-road motorcycle" includes a motorcycle that was originally issued a certificate of title and registered for highway use under Iowa Code chapter 321, but which contains design features that enable operation over natural terrain.

"Off-road utility vehicle" means a motorized flotation-tire vehicle with not less than four and not more than eight low-pressure tires that is limited in engine displacement to less than 1,500 cubic centimeters and in total dry weight to not more than 1,800 pounds and that has a seat that is of bucket or bench design, not intended to be straddled by the operator, and a steering wheel or control levers for control. A motorized vehicle that was previously titled or is currently titled under Iowa Code chapter 321 shall not be registered or operated as an off-road utility vehicle.

"Operator" means a person who operates or is in actual physical control of a regulated vehicle.

"Owner" means a person, other than a lienholder, having the property right in or title to an all-terrain vehicle. "Owner" includes a person entitled to the use or possession of an all-terrain vehicle subject to an interest in another person, reserved or created by agreement and securing payment or performance of an obligation. "Owner" excludes a lessee under a lease not intended as security.

"Public land" means land owned by the federal government, the state of Iowa, or a political subdivision of the state and land acquired or developed for public recreation pursuant to Iowa Code section 321I.8.

"Regulated vehicle" means all-terrain vehicles, off-road motorcycles, and off-road utility vehicles, either collectively or individually.

"Roadway" means that portion of a highway improved, designed, or ordinarily used for vehicular travel.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.2(321I) Off-road motorcycles.

46.2(1) Off-road motorcycles shall be considered all-terrain vehicles for the purpose of:

a. Registration requirements of this chapter; and

b. Titling requirements of this chapter, if a title has not previously been issued under Iowa Code chapter 321.

46.2(2) An operator of an off-road motorcycle is subject to the provisions of Iowa Code chapter 321I and this chapter, except that the operator is exempt from the safety instruction and certification program requirements of Iowa Code chapter 321I.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.3(321I) Off-road utility vehicles.

46.3(1) An owner of an off-road utility vehicle operating the off-road utility vehicle on public land or ice, a designated riding area, or a designated riding trail shall register the off-road utility vehicle in accordance with Iowa Code chapter 321I and this chapter.

46.3(2) An operator of an off-road utility vehicle is subject to the provisions of Iowa Code section 321.234A and chapter 321I and this chapter, except that the operator is exempt from the safety instruction and certification program requirements of Iowa Code chapter 321I.

46.3(3) An operator of an off-road utility vehicle shall not operate the vehicle on a designated riding area or designated riding trail unless the department has posted signage indicating the riding area or trail is open to the operation of off-road utility vehicles.

46.3(4) Off-road utility vehicles are exempt from the dealer registration and dealer titling requirements of Iowa Code chapter 321I and this chapter.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.4(321I) Operation on roadways, highways, streets, and snowmobile trails. A person shall not operate a regulated vehicle upon roadways, highways, streets, or snowmobile trails except as provided in Iowa Code section 321.234A and 2009 Iowa Code Supplement section 321I.10.

NOTE: Additional driving and operation limitations are listed in Iowa Code section 321I.14.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.5(321I) Registration for all-terrain vehicles and off-road motorcycles.

46.5(1) *General.* A person shall not operate, maintain, or give permission for the operation or maintenance of an all-terrain vehicle or off-road motorcycle on public land, a designated riding area, a designated riding trail, or ice unless the all-terrain vehicle or off-road motorcycle:

a. Is registered in accordance with the requirements of Iowa Code chapter 321I and this chapter;

b. Displays a current annual nonresident user permit decal issued as provided in rule 571—46.6(321I); or

c. Is exempt from registration pursuant to Iowa Code section 321I.9.

46.5(2) *Registration requirements.*

a. The owner of each all-terrain vehicle or off-road motorcycle required to be registered shall file an application for registration with the department through a county recorder and pay all applicable fees pursuant to Iowa Code section 321I.4 and these rules, except that an all-terrain vehicle dealer shall make application and pay all applicable registration and title fees on behalf of a purchaser of an all-terrain vehicle or off-road motorcycle.

(1) Application forms. The applicant shall use DNR Form 542-8067 in making application for registration. In the event the applicant does not have documentation required by DNR Form 542-8067, the applicant shall use DNR Form 542-8065 and may be required to secure a bond consistent with the requirements of 571—Chapter 50.

(2) Fees. The applicant shall pay the following fees: $15 for the permit fee; $1 for the writing fee; and $1.50 for the administrative fee. In addition, a county recorder may collect an additional 25 cents for the writing fee if the county recorder issues the registration.

b. At such time the department or the county recorder is satisfied with the application and has received the required fees, the department or county recorder shall issue to the applicant a registration certificate and registration decal.

46.5(3) *Preregistration grace period.*

a. *Dealer purchases.* An unregistered all-terrain vehicle or off-road motorcycle sold by a dealer to an Iowa resident for use in Iowa shall bear a card made of pasteboard or other similar material that includes the words "registration applied for" and the date of purchase. Such card shall entitle the

purchaser to operate the all-terrain vehicle or off-road motorcycle for 45 days immediately following the purchase. The purchaser shall place this card on the rear of the all-terrain vehicle and the steering yoke of an off-road motorcycle in a position so as to be clearly visible at all times and maintained in a legible manner. The operator of any all-terrain vehicle or off-road motorcycle displaying a "registration applied for" card described in this paragraph shall carry and provide upon request to any peace officer a valid bill of sale for the all-terrain vehicle or off-road motorcycle.

b. *Nondealer purchases.* All-terrain vehicles and off-road motorcycles may be sold by nondealers, and the registration grace period may apply depending on the current registration of the vehicle.

(1) An all-terrain vehicle or off-road motorcycle that is currently registered in the state of Iowa may be legally operated for 30 days before it is registered under the purchaser's name.

(2) An all-terrain vehicle or off-road motorcycle not currently registered in the state of Iowa shall not be operated until it is titled and registered in the purchaser's name. Valid registration in another state does not authorize preregistration operation.

46.5(4) *Registration—renewals.* Every all-terrain vehicle and off-road motorcycle registration certificate and registration decal expires at midnight December 31 of the year issued or at the time specified on the registration decal. Applications for renewal shall be completed pursuant to Iowa Code section 321I.7.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.6(321I) Nonresident user permits.

46.6(1) A nonresident wishing to operate a regulated vehicle, other than such vehicle owned by a resident and registered pursuant to Iowa Code chapter 321I, on public land, a designated riding area, a designated riding trail, or ice of this state must first obtain a user permit from the department.

46.6(2) The department, a county recorder or license agent designated by the director may issue nonresident user permits. The applicant shall pay the following fees for a user permit: $15 for the permit fee; $1 for a writing fee; and $1.50 for an administrative fee. In the event the county recorder issues such a permit, the county recorder may charge an additional 25 cents for the writing fee.

46.6(3) A nonresident user permit issued under this rule shall be valid for the calendar year or time period specified in the permit and be limited to the vehicle specified at the time of application.

46.6(4) Nonresident user permits are issued to a vehicle and are not transferable.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.7(321I) Display of registration and user permit decals. The owner shall display the registration decal or nonresident user permit decal as follows:

46.7(1) *All-terrain vehicle.* The decal shall be affixed to the rear of the all-terrain vehicle so that the decal is clearly visible.

46.7(2) *Off-road motorcycle.* The decal shall be affixed to the steering yoke in such a manner that the decal does not cover up the vehicle identification number and is clearly visible.

46.7(3) *Off-road utility vehicle.* The decal shall be affixed to the rear of the vehicle so that the decal is clearly visible.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.8(321I) Registration certificate.

46.8(1) An operator of a regulated vehicle shall carry the registration certificate either in such vehicle or on the person of the operator when the regulated vehicle is in use.

46.8(2) The operator of a regulated vehicle shall exhibit the registration certificate to all of the following:

a. To a peace officer or department personnel upon request;

b. To a person injured in an accident involving the regulated vehicle, or that person's agent;

c. To the owner or operator of another regulated vehicle when the regulated vehicle is involved in a collision or accident of any nature with the other regulated vehicle, or that person's agent;

d. To the owner of personal or real property when the regulated vehicle is involved in a collision or accident of any nature with the property of the other person, or that person's agent; and

e. To the property owner or tenant when the regulated vehicle is being operated on private property without permission from the property owner or tenant, or that person's agent.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.9(321I) Owner's certificate of title.

46.9(1) The owner of an all-terrain vehicle or off-road motorcycle acquired on or after January 1, 2000, other than an all-terrain vehicle used exclusively as a farm implement or an off-road motorcycle previously issued a title pursuant to Iowa Code chapter 321, shall apply to the county recorder of the county in which the owner resides for a certificate of title for the all-terrain vehicle or off-road motorcycle. The owner shall make application within 30 days after acquisition of the all-terrain vehicle or off-road motorcycle, using DNR Form 542-8067, and shall include the required fees set out in Iowa Code section 321I.32.

46.9(2) A certificate of title issued by the county recorder shall be on DNR Form 542-0974.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.10(321I) Procedures for application and for issuance of a vehicle identification number (VIN) for homebuilt regulated vehicles.

46.10(1) A person, other than a manufacturer, who constructs or rebuilds a regulated vehicle for which there is no legible VIN may make application to the department on DNR Form 542-8065 for the issuance of a new VIN. The application process shall include an inspection of the regulated vehicle by the department. If the application is approved, the VIN shall be affixed to the vehicle by a conservation officer. The completed application shall then be surrendered to the county recorder.

46.10(2) The conservation officer shall permanently affix the VIN as follows:

a. *All-terrain vehicle.* The VIN shall be affixed to the frame under the seat.

b. *Off-road motorcycle.* The VIN shall be affixed to the steering yoke.

c. *Off-road utility vehicle.* The VIN shall be affixed to the frame under the seat.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.11(321I) Accident report.

46.11(1) Whenever any regulated vehicle is involved in an accident resulting in injury or death to any person or property damage amounting to $1,000 or more, the operator or a person acting for the operator shall immediately notify the county sheriff or another law enforcement agency in the state.

46.11(2) If the accident occurred on public land, a designated riding area, a designated riding trail, or ice under the jurisdiction of the commission, the operator shall file a report of the accident with the department within 72 hours. The report shall be on DNR Form 542-8093, Off-Highway Vehicle Incident Report Form.

46.11(3) Accidents other than those specified in 46.11(2) shall be reported as required in Iowa Code section 321.266.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.12(321I) Sound level limitation.

46.12(1) No person shall operate an all-terrain vehicle or off-road motorcycle that is constructed or altered in a manner that noise emitted from the all-terrain vehicle or off-road motorcycle exceeds 96 decibels on the A scale when measured in the manner prescribed in the revised 2008-05, Society of Automotive Engineers Standard J1287, titled "Measurement of Exhaust Sound Pressure Levels of Stationary Motorcycles."

46.12(2) The Society of Automotive Engineers Standard J1287, titled "Measurement of Exhaust Sound Pressure Levels of Stationary Motorcycles," is available for inspection at the following locations:

a. Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319.

b. State Law Library, Capitol Building, 1007 East Grand Avenue, Des Moines, Iowa 50319.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.13 to **46.20** Reserved.

DIVISION II
ALL-TERRAIN VEHICLE DEALERS

571—46.21(321I) Purpose. The rules in this division apply to registered all-terrain vehicle dealers, manufacturers, and distributors. These rules establish minimum standards for all-terrain vehicle dealers as authorized under 2009 Iowa Code Supplement section 321I.22(9).
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.22(321I) Definitions. For purposes of this division, the following definitions shall apply:

"Consumer use" means use of an all-terrain vehicle for business or pleasure, not for sale at retail, by a person who has obtained a certificate of title and has registered the vehicle in conformance with Iowa Code chapter 321I.

"Dealer" means a person engaged in the business of buying, selling, or exchanging all-terrain vehicles required to be registered under Iowa Code chapter 321I and this chapter and who has an established place of business for that purpose in this state.

"Designated location" means the primary place of business of the dealer or a building actually occupied by a dealer where the public and the department may contact the dealer during regular business hours.

"Distributor" means a person, resident or nonresident, who sells or distributes all-terrain vehicles to all-terrain vehicle dealers in this state or who maintains distributor representatives.

"Engaged in the business," or similar wording, means doing any of the following acts for the purpose of selling all-terrain vehicles at retail: acquiring, selling, exchanging, holding, offering, displaying, brokering, accepting on consignment or conducting a retail auction, or acting as an agent for the purpose of doing any of these acts. A person selling at retail more than five all-terrain vehicles during a 12-month period may be presumed to be engaged in the business.

"Established place of business" means the place actually occupied either continuously or at regular periods by a dealer or manufacturer where the books and records are kept and the dealer's or manufacturer's business is primarily transacted.

"Manufacturer" means a person engaged in the business of constructing or assembling all-terrain vehicles required to be registered under Iowa Code chapter 321I and this chapter and who has an established place of business for that purpose in this state.

"Manufacturer's certificate of origin" means a certification signed by the manufacturer, distributor or importer that the all-terrain vehicle described has been transferred to the person or dealer named, and that the transfer is the first transfer of the vehicle in ordinary trade and commerce. A manufacturer's certificate of origin may also be referred to as a manufacturer's statement of origin.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.23(321I) Dealer's established place of business. A dealer's established place of business shall include landline telephone service and an adequate office area for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all-terrain vehicles offered for sale.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.24(321I) Zoning. Dealers licensed under these rules must comply with applicable local zoning ordinances. Upon request by the department, a dealer shall provide to the department written evidence, issued by the office responsible for the enforcement of zoning ordinances in the city or county where the dealer's established place of business is located, that the dealer's established place of business complies with all applicable zoning provisions.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.25(321I) Sales tax permit. A dealer shall provide to the department written evidence that the dealer has obtained a sales tax permit issued by the department of revenue.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.26(321I) Special registration certificates for manufacturers, distributors, and dealers.

46.26(1) A manufacturer, distributor, or dealer owning an all-terrain vehicle required to be registered under Iowa Code chapter 321I and this chapter may operate the unregistered all-terrain vehicle for purposes of transporting, testing, demonstrating, or selling it if both of the following requirements are met:

a. The manufacturer, distributor, or dealer obtains from the department a special registration certificate containing a general identification number in accordance with Iowa Code section 321I.22. An application for a special registration certificate shall be submitted on DNR Form 542-0846; and

b. The manufacturer, distributor, or dealer has the assigned identification number printed upon or attached to a removable sign which is temporarily but firmly attached to the all-terrain vehicle being used.

46.26(2) If a manufacturer, distributor, or dealer has an established place of business in more than one location, the manufacturer, distributor, or dealer shall obtain from the department a separate and distinct special registration certificate and general identification number for each place of business.

46.26(3) Duplicate special registration certificates may be obtained pursuant to the conditions set forth in Iowa Code section 321I.22.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.27(321I) Information provided to purchaser. At the time of sale, a dealer shall provide all purchasers of all-terrain vehicles with both (1) a copy of current all-terrain vehicle laws and regulations governing the usage of all-terrain vehicles in the state of Iowa, and (2) the most up-to-date list of public places open for all-terrain vehicle usage. The department shall provide this required information on its Web site, www.iowadnr.gov. Information provided on the department's Web site shall be deemed current and the most up-to-date information for purposes of this rule.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.28(321I) Right of inspection. The department or any peace officer has the authority to inspect the following at any dealer location: (1) all-terrain vehicles or component parts of vehicles, (2) business records, and (3) manufacturers' certificates of origin, certificates of title and other evidence of ownership for all-terrain vehicles offered for sale. The department has the right at any time to verify compliance with all statutory and regulatory requirements by a dealer registered under Iowa Code chapter 321I.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.29(321I) Denial or revocation. The department may deny a dealer application or revoke a dealer registration certificate when the director determines the applicant or dealer has violated any rule of this chapter or Iowa Code chapter 321I or when continuation of the permit is not in the public interest. Such denial or revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the denial or revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation or denial, the applicant or dealer, whichever is applicable, may file a notice of appeal, requesting a contested case pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the permit be issued or reinstated.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.30 to **46.50** Reserved.

DIVISION III
REGULATION OF DESIGNATED RIDING AREAS

571—46.51(321I) Definitions. In addition to the definitions in division I and division II of this chapter, the following definitions shall apply:

"Direct supervision" means to provide supervision of another person while maintaining visual and verbal contact at all times.

"Local sponsor" means the entity that owns the designated riding area or is otherwise responsible for the day-to-day operations of the designated riding area. A local sponsor may or may not be a unit of government.

"Operate" means to ride in or on, other than as a passenger, use, or control the operation of a regulated vehicle in any manner, whether or not the regulated vehicle is moving.

"Regulated vehicle" means all-terrain vehicles, off-road motorcycles, and off-road utility vehicles, either collectively or individually.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.52(321I) Designated riding areas.

46.52(1) Designated off-highway vehicle (OHV) riding areas shall be considered to be public land, available and open to the public to use and enjoy consistent with these rules.

46.52(2) The following areas are hereby established as designated riding areas:

a. Bluff Creek OHV Park, Mahaska County.

b. Lakeview OHV Park, Johnson County.

c. Gypsum City OHV Park, Webster County.

d. Nicholson-Ford OHV Park, Marshall County.

e. Rathbun OHV Park, Appanoose County.

f. River Valley OHV Park, Pottawattamie County.

g. Riverview OHV Park, Black Hawk County.

h. Tama County OHV Park, Tama County.

46.52(3) A local sponsor may request that the commission adopt the local sponsor's riding area as a designated riding area by contacting the chief of the department's law enforcement bureau in writing and providing information, as requested by the department, that demonstrates that the local sponsor's proposed designated riding area meets the minimum qualifications described in these rules. All studies or surveys required by these rules shall be at the local sponsor's expense. The department may require additional surveys or studies and conduct an on-site evaluation for each proposed designated riding area to determine whether the department should recommend that the commission adopt the proposed area as a designated riding area. The commission may adopt additional designated riding areas that meet the following minimum qualifications:

a. The site and plan for development and management is suitable for off-highway vehicle recreation. The department shall give greater consideration to sites that were previously disturbed areas, such as agricultural lands, mining operations, road surfaces or other intensive land uses that have resulted in the elimination of high-quality natural areas, native plant communities, critical habitats and cultural resources. Soil survey reports for the trail portions of the proposed designated riding area shall indicate the general soil classification of the riding areas and must indicate that those soils are of moderate risk or less for path or trail development.

b. There is demand for the proposed designated riding area. Consideration shall be given to nearby populations, distance to other OHV facilities, partnership possibilities and local support.

c. The local sponsor demonstrates a willingness and ability to maintain the proposed designated riding area consistent with these rules.

d. There is evidence that adjacent property owners, including those within the viewshed and within earshot of the proposed designated riding area, that exist at the time of establishment have been notified of the plan and their concerns have been addressed.

e. The proposed development and management of the proposed designated riding area comply with local, state or federal laws, including without limitation zoning ordinances and accommodation laws.

f. Any federal- or state-listed threatened or endangered species are identified and a plan to ensure that the development and management of the proposed designated riding area would not negatively impact those species is included.

g. Any cultural, historical or high-quality natural resources on the site are identified and a plan to ensure that the development and management of the proposed designated riding area would not

negatively impact those resources is included. High-quality areas include those areas of high-quality native plant communities, highly restorable native plant communities or other areas which provide critical wildlife habitat. In addition, if a site contains fragments of high-quality areas, but has been determined by the commission as suitable for use as a designated riding area, the local sponsor shall include in the plan how it will protect and enhance those fragments.

46.52(4) Designated riding areas approved by the commission shall be subject to these rules and shall be managed according to the plan approved by the commission. Major modifications to the plan, including expansions, must be approved by the commission for the designated riding area to continue to be a recognized designated riding area under these rules.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.53(321I) Department law enforcement at designated riding areas. A local sponsor may request that the department provide law enforcement and other management assistance and oversight at the designated riding area, including adjacent parking and unloading areas, and at camping areas if applicable. The department, in its sole discretion, may provide such law enforcement and other management assistance and oversight it deems appropriate, provided that the local sponsor and the department enter into a written agreement describing what role and responsibilities department personnel shall have at the park and affording the department the right to terminate such agreement at any time, for any reason.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.54(321I) General rules for regulated vehicle operation in designated riding areas. Operation on designated riding areas is limited to regulated vehicles as defined in this chapter and as described below:

46.54(1) *Allowable vehicles.* Persons shall operate only the vehicles allowed at a designated riding area that is signed as open for the specified vehicle.

46.54(2) *Compliance with signs.* Persons at designated riding areas shall comply with all signs erected and maintained by the local sponsor or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I).

46.54(3) *Hours of operation.* Designated riding areas shall be open from sunrise to sunset, unless signed by the local sponsor, or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I), as open for operation during other hours as approved by the department. There may be instances when operating regulated vehicles in dark conditions is permissible. In those instances, persons operating regulated vehicles between sunset and sunrise, or in otherwise dark conditions, in designated riding areas must equip their regulated vehicles with a headlight and a taillight and use such lights.

46.54(4) *Registration required.* A person shall not operate, maintain, or give permission for the operation or maintenance of a regulated vehicle in a designated riding area unless the regulated vehicle is registered and such registration is displayed in accordance with Iowa Code chapter 321I and these rules. This requirement includes nonresidents operating regulated vehicles in a designated riding area who are required to have nonresident user permits for their regulated vehicles.

46.54(5) *Safety equipment required.* All operators and their passengers shall wear helmets while operating a regulated vehicle on a designated riding area, including parking and unloading areas. The local sponsor, or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I), may post signs that require operators to wear additional safety gear depending on conditions.

46.54(6) *Working brakes.* Every regulated vehicle operated in a designated riding area, including parking and unloading areas, shall be equipped with working brakes.

46.54(7) *Minors—supervision.* A person under 12 years of age shall not operate an all-terrain vehicle or an off-road motorcycle on a designated riding area unless one of the following applies:

a. The person is taking a prescribed education training course and the operation of the vehicle is under the direct supervision of a certified education instructor.

b. The operation of the vehicle is under the direct supervision of a responsible parent or guardian of at least 18 years of age who is experienced in all-terrain vehicle or off-road motorcycle operation and who possesses a valid driver's license as defined in Iowa Code section 321.1.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.55(321I) Unauthorized vehicles. The local sponsor, or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I), may tow unauthorized vehicles, including hauling equipment. Towing shall be at the owner's expense.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.56(321I) Parking and unloading areas. All vehicles, other than regulated vehicles, and trailers shall be parked in designated parking areas. No such vehicles, other than regulated vehicles, shall be left unattended in any park drive access point, unloading area, road or highway, except in the case of an emergency.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.57(321I) Operation with passengers.

46.57(1) Persons shall not operate regulated vehicles on designated riding areas with a passenger unless the regulated vehicle is designed and constructed according to the manufacturer's specifications to carry a passenger. Passengers shall not ride on regulated vehicles that have been modified from the manufacturer's original design and construction to carry a passenger.

46.57(2) A person shall not operate a regulated vehicle in a designated riding area with a passenger without possession of a valid driver's license as defined in Iowa Code section 321.1.

46.57(3) The number of passengers on a regulated vehicle in a designated riding area shall not exceed the manufacturer's capacity recommendation and shall not exceed the number of passenger restraints originally installed by the manufacturer.

46.57(4) A passenger on an all-terrain vehicle or off-road motorcycle must be seated behind the operator and have the physical ability to securely hold on to the operator or passenger handles.

46.57(5) Passengers on an off-road utility vehicle must be able to place both feet flat on the floor boards with their backs resting against the seat back.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.58(321I) Off-road utility vehicle requirements. The following additional restrictions apply to the operation of off-road utility vehicle operation in designated riding areas signed open to such use:

46.58(1) Driver's license required. A person shall not operate an off-road utility vehicle in a designated riding area without possession of a valid driver's license as defined in Iowa Code section 321.1.

46.58(2) Vehicles shall not be homebuilt or substantially modified from the manufacturer's specifications in the sole opinion of the director or the director's designee.

46.58(3) Vehicles must be equipped with a roll-over protection system (ROPS) installed by the manufacturer.

46.58(4) Vehicles must be equipped with manufacturer seat belts or equivalent that are in good working order. The operator and all passengers must wear seat belts at all times the vehicle is in motion.

46.58(5) The operator and all passengers must keep their hands, arms, legs, and feet inside the vehicle at all times the vehicle is in motion.

46.58(6) The vehicle must be no wider than 62 inches.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.59(321I) Youth operational areas. The local sponsor, or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I), may establish areas for youth all-terrain vehicle and off-road motorcycle operation on designated riding areas; may restrict the age of the operator and the size of the all-terrain vehicle; may limit the engine displacement for both all-terrain vehicles and off-road motorcycles; and shall post such restrictions.
[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.60(321I) Unlawful operation. A person shall not operate a regulated vehicle in any of the following instances:

46.60(1) At a rate of speed greater than reasonable or proper under all existing circumstances or greater than the posted speed, whichever is less. In no event shall a person operate any vehicle in a parking area of or adjacent to a designated riding area in excess of 5 miles per hour.

46.60(2) In a careless, reckless, or negligent manner so as to endanger the person or property of another or to cause injury or damage thereto.

46.60(3) While under the influence of intoxicating substances or narcotics or habit-forming drugs.

46.60(4) Without a lighted headlight and taillight from sunset to sunrise and at such other times when conditions provide insufficient lighting to render clearly discernible persons and vehicles at a distance of 500 feet ahead.

46.60(5) Off established or marked trails or in prohibited areas.

46.60(6) In violation of official signs posted by the local sponsor or by the department consistent with its relationship to the local sponsor under rule 571—46.53(321I).

46.60(7) If the person's license to operate a motor vehicle is under suspension, revocation, bar, disqualification, cancellation or denial by this state or any other state.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.61(321I) Alcohol prohibited. Persons shall not consume or possess alcohol in designated riding areas, except that the consumption and possession of alcohol shall be permitted at designated camping areas.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.62(321I) Pets. Pets shall not be permitted in designated riding areas, except for parking and camping areas, if any.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

571—46.63(321I) Camping. Camping shall not be permitted in designated riding areas, except for areas specifically designed for and identified by the local sponsor, or the department consistent with its relationship to the local sponsor under rule 571—46.53(321I), for such use. In such instances, camping rules shall be posted in such areas.

[**ARC 8878B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement Iowa Code chapter 321I.

[Filed ARC 8878B (Notice ARC 8730B, IAB 5/5/10), IAB 6/30/10, effective 8/4/10]

CHAPTER 47
SNOWMOBILES

DIVISION I
REGISTRATION, RENEWAL, TITLING, DECAL PLACEMENT AND ACCIDENT REPORTS

571—47.1(321G) Definitions. For purposes of this chapter, the following definitions shall apply:

"Commission" means the natural resource commission established in Iowa Code section 455A.5.

"Department" means the department of natural resources established in Iowa Code section 455A.2.

"Operator" means a person who operates or is in actual physical control of a snowmobile.

"Owner" means a person, other than a lienholder, having the property right in or title to a snowmobile. "Owner" includes a person entitled to the use or possession of a snowmobile subject to an interest in another person, reserved or created by agreement and securing payment or performance of an obligation. "Owner" does not include a lessee under a lease not intended as security.

"Public land" means land owned by the federal government, the state of Iowa, or a political subdivision of the state and land acquired or developed for public recreation pursuant to Iowa Code section 321G.7.

"Roadway" means that portion of a highway improved, designed, or ordinarily used for vehicular travel.

"Snowmobile" means a motorized vehicle weighing less than 1,000 pounds which uses sled-type runners or skis, endless belt-type tread with a width of 48 inches or less, or any combination of runners, skis, or tread and is designed for travel on snow or ice. "Snowmobile" does not include an all-terrain vehicle, as defined in Iowa Code section 321I.1, which has been altered or equipped with runners, skis, belt-type tracks, or treads.

[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.2(321G) Operation on roadways, highways, streets and snowmobile trails. A person shall not operate a snowmobile upon roadways, highways, streets, or designated snowmobile trails except as provided in Iowa Code section 321G.9.

NOTE: Additional driving and operation limitations are listed in Iowa Code section 321G.13.

[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.3(321G) Registration for snowmobiles.

47.3(1) *General.* A person shall not operate, maintain, or give permission for the operation or maintenance of a snowmobile on public land, a designated snowmobile trail, or ice unless the snowmobile:

a. Is registered in accordance with the requirements of Iowa Code chapter 321G and this chapter;

b. Displays a current annual nonresident user permit decal issued as provided in rule 571—47.4(321G); or

c. Is exempt from registration pursuant to Iowa Code section 321G.8.

47.3(2) *Registration requirements.*

a. The owner of each snowmobile required to be registered shall file an application for registration with the department through a county recorder and pay all applicable fees pursuant to Iowa Code section 321G.4 and these rules, except that a snowmobile dealer shall make application and pay all applicable registration and title fees on behalf of a purchaser of a snowmobile.

(1) Application forms. The applicant shall use DNR Form 542-8067 in making application for registration. In the event the applicant does not have the documentation required by DNR Form 542-8067, the applicant shall use DNR Form 542-8065 and may be required to secure a bond consistent with the requirements of 571—Chapter 50.

(2) Fees. The applicant shall pay the following fees: $15 for the permit fee; $1 for the writing fee; and $1.50 for the administrative fee. In addition, a county recorder may collect an additional 25 cents for the writing fee if the county recorder issues the registration.

b. At such time the department or the county recorder is satisfied with the application and has received the required fees, the department or county recorder shall issue to the applicant a registration certificate and registration decal.

47.3(3) *Preregistration grace period.*

a. *Dealer purchases.* An unregistered snowmobile sold by a dealer to an Iowa resident for use in Iowa shall bear a card made of pasteboard or other similar material that includes the words "registration applied for" and the date of purchase. Such card shall entitle the purchaser to operate the snowmobile for 45 days immediately following the purchase. The purchaser shall place this card on the windshield area of the snowmobile in a position so as to be clearly visible at all times and maintained in a legible manner. The operator of any snowmobile displaying a "registration applied for" card described in this paragraph shall carry and provide upon request to any peace officer a valid bill of sale for the snowmobile.

b. *Nondealer purchases.* Snowmobiles may be sold by nondealers, and the registration grace period may apply depending on the current registration of the vehicle.

(1) A snowmobile that is currently registered in the state of Iowa may be legally operated for 30 days before it is registered under the purchaser's name.

(2) A snowmobile not currently registered in the state of Iowa shall not be operated until it is titled and registered in the purchaser's name. Valid registration in another state does not authorize preregistration operation.

47.3(4) *Registration—renewals.* Every snowmobile registration certificate and registration decal expires at midnight December 31 of the year issued or at the time specified on the registration decal. Applications for renewal shall be completed pursuant to Iowa Code section 321G.6.

[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.4(321G) Nonresident user permits.

47.4(1) A nonresident wishing to operate a snowmobile, other than such vehicle owned by a resident and registered pursuant to Iowa Code chapter 321G, on public land, a designated snowmobile trail, or ice of this state must first obtain a user permit from the department.

47.4(2) The department, a county recorder or license agent designated by the director may issue nonresident user permits. The applicant shall pay the following fees for a user permit: $15 for the permit fee; $1 for a writing fee; and $1.50 for an administrative fee. In the event the county recorder issues such a permit, the county recorder may charge an additional 25 cents for the writing fee.

47.4(3) A user permit issued under this rule shall be valid for the calendar year or time period specified in the permit and shall be limited to the vehicle specified at the time of application.

47.4(4) Nonresident user permits are issued to a vehicle and are not transferable.

[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.5(321G) Display of registration and user permit decals. The owner of a snowmobile shall display the registration decal or nonresident user permit decal on the windshield of the snowmobile so that the decal is clearly visible. If the snowmobile does not have a windshield, then the decal shall be affixed to the area of the hood near the headlamp so that the decal is clearly visible.

[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.6(321G) Registration certificate.

47.6(1) An operator of a snowmobile shall carry the registration certificate either in such vehicle or on the person of the operator when the snowmobile is in use.

47.6(2) The operator of a snowmobile shall exhibit the registration certificate to all of the following:

a. To a peace officer or department personnel upon request;

b. To a person injured in an accident involving the snowmobile, or that person's agent;

c. To the owner or operator of another snowmobile when the snowmobile is involved in a collision or accident of any nature with the other snowmobile, or that person's agent;

d. To the owner of personal or real property when the snowmobile is involved in a collision or accident of any nature with the property of the other person, or that person's agent; and

e. To the property owner or tenant when the snowmobile is being operated on private property without permission from the property owner or tenant, or that person's agent.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.7(321G) Owner's certificate of title.

47.7(1) The owner of a snowmobile acquired on or after January 28, 1998, other than a snowmobile used exclusively as a farm implement or a previously registered snowmobile that is more than 30 years old, shall apply to the county recorder of the county in which the owner resides for a certificate of title for the snowmobile. The owner shall make application within 30 days after acquisition of the snowmobile, using DNR Form 542-8067, and shall include the required fees set out in Iowa Code section 321G.30.

47.7(2) A certificate of title issued by the county recorder shall be on DNR Form 542-0974.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.8(321G) Procedures for application and for issuance of a vehicle identification number (VIN) for homebuilt snowmobiles.

47.8(1) A person, other than a manufacturer, who constructs or rebuilds a snowmobile for which there is no legible VIN may make application to the department on DNR Form 542-8065 for the issuance of a new VIN. The application process shall include an inspection of the snowmobile by the department. If the application is approved, the VIN shall be affixed to the vehicle by a conservation officer. The completed application shall then be surrendered to the county recorder.

47.8(2) The conservation officer shall permanently affix the VIN to the frame under the seat of the snowmobile.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.9(321G) Accident report.

47.9(1) Whenever any snowmobile is involved in an accident resulting in injury or death to anyone or property damage amounting to $1,000 or more, the operator or someone acting for the operator shall immediately notify the county sheriff or another law enforcement agency of the state.

47.9(2) If the accident occurred on public land, a designated snowmobile trail, or ice under the jurisdiction of the commission, the operator shall file a report of the accident with the department within 72 hours. The report shall be on DNR Form 542-8093, Off-Highway Vehicle Incident Report Form.

47.9(3) Accidents other than those specified in 47.9(2) shall be reported as required in Iowa Code section 321.266.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.10 to **47.20** Reserved.

DIVISION II
SNOWMOBILE DEALERS

571—47.21(321G) Purpose. The rules in this division apply to registered snowmobile dealers, manufacturers, and distributors. These rules establish minimal standards for snowmobile dealers as authorized under Iowa Code Supplement section 321G.21.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.22(321G) Definitions. For purposes of this division, the following definitions shall apply:

"Consumer use" means use of a snowmobile for business or pleasure, not for sale at retail, by a person who has obtained a certificate of title and has registered the vehicle in conformance with Iowa Code chapter 321G.

"Dealer" means a person engaged in the business of buying, selling, or exchanging snowmobiles required to be registered under Iowa Code chapter 321G and this chapter and who has an established place of business for that purpose in this state.

"Designated location" means the primary place of business of the dealer or a building actually occupied by a dealer where the public and the department may contact the dealer during regular business hours.

"Distributor" means a person, resident or nonresident, who sells or distributes snowmobiles to snowmobile dealers in this state or who maintains distributor representatives.

"Engaged in the business," or similar wording, means doing any of the following acts for the purpose of selling snowmobiles at retail: acquiring, selling, exchanging, holding, offering, displaying, brokering, accepting on consignment or conducting a retail auction, or acting as an agent for the purpose of doing any of these acts. A person selling at retail more than five snowmobiles during a 12-month period may be presumed to be engaged in the business.

"Established place of business" means the place actually occupied either continuously or at regular periods by a dealer or manufacturer where the books and records are kept and the dealer's or manufacturer's business is primarily transacted.

"Manufacturer" means a person engaged in the business of constructing or assembling snowmobiles required to be registered under Iowa Code chapter 321G and this chapter and who has an established place of business for that purpose in this state.

"Manufacturer's certificate of origin" means a certification signed by the manufacturer, distributor or importer that the snowmobile described has been transferred to the person or dealer named, and that the transfer is the first transfer of the vehicle in ordinary trade and commerce. A manufacturer's certificate of origin may also be referred to as a manufacturer's statement of origin.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.23(321G) Dealer's established place of business. A dealer's established place of business shall include landline telephone service and an adequate office area for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all snowmobiles offered for sale.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.24(321G) Zoning. Dealers licensed under these rules must comply with applicable local zoning ordinances. Upon request by the department, a dealer shall provide to the department written evidence issued by the office responsible for the enforcement of zoning ordinances in the city or county where the dealer's established place of business is located that the dealer's established place of business complies with all applicable zoning provisions.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.25(321G) Sales tax permit. A dealer shall provide to the department written evidence that the dealer has obtained a sales tax permit issued by the department of revenue.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.26(321G) Special registration certificates for manufacturers, distributors and dealers.

47.26(1) A manufacturer, distributor, or dealer owning a snowmobile required to be registered under Iowa Code chapter 321G and this chapter may operate the unregistered snowmobile for purposes of transporting, testing, demonstrating, or selling it if both of the following requirements are met:

a. The manufacturer, distributor, or dealer obtains from the department a special registration certificate and decal containing a general identification number in accordance with Iowa Code section 321G.21. An application for a special registration certificate shall be submitted on DNR Form 542-0846; and

b. The manufacturer, distributor, or dealer has the assigned decal attached to a removable sign which is temporarily but firmly attached to the snowmobile being used.

47.26(2) If a manufacturer, distributor, or dealer has an established place of business in more than one location, the manufacturer, distributor, or dealer shall obtain from the department a separate and distinct special registration certificate, decal and general identification number for each place of business.

47.26(3) Duplicate special registration certificates and decals may be obtained pursuant to the conditions set forth in Iowa Code section 321G.21.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.27(321G) Information provided to purchasers. At the time of sale, a dealer shall provide all purchasers of snowmobiles with both (1) a copy of current snowmobile laws and regulations governing the usage of snowmobiles in the state of Iowa, and (2) the most up-to-date list of public places open for snowmobile usage. The department shall provide this required information on its Web site, www.iowadnr.gov. Information provided on the department's Web site shall be deemed current and the most up-to-date information for purposes of this rule.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.28(321G) Right of inspection. The department or any peace officer has the authority to inspect the following at any dealer location: (1) snowmobiles or component parts of vehicles, (2) business records, and (3) manufacturers' certificates of origin, certificates of title and other evidence of ownership for snowmobiles offered for sale. The department has the right at any time to verify compliance with all statutory and regulatory requirements by a dealer registered under Iowa Code chapter 321G.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

571—47.29(321G) Denial or revocation. The department may deny a dealer application or revoke a dealer registration certificate when the director determines the applicant or dealer has violated any rule of this chapter or Iowa Code chapter 321G or when continuation of the permit is not in the public interest. Such denial or revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the denial or revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation or denial, the applicant or dealer, whichever is applicable, may file a notice of appeal, requesting a contested case pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the permit be issued or reinstated.
[**ARC 8879B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement Iowa Code chapter 321G.

[Filed ARC 8879B (Notice ARC 8731B, IAB 5/5/10), IAB 6/30/10, effective 8/4/10]

CHAPTER 50
ALL-TERRAIN VEHICLE, OFF-ROAD MOTORCYCLE, OFF-ROAD UTILITY VEHICLE, SNOWMOBILE AND VESSEL BONDING

[Prior to 12/31/86, Conservation Commission[290] Ch 50]

571—50.1(321G,321I) Definitions.

"All-terrain vehicle" means a motorized flotation-tire vehicle with not less than three and not more than six low-pressure tires that is limited in engine displacement to less than 1,000 cubic centimeters and in total dry weight to less than 1,000 pounds and that has a seat or saddle designed to be straddled by the operator and handlebars for steering control.

"Off-road motorcycle" means a two-wheeled motor vehicle that has a seat or saddle designed to be straddled by the operator and handlebars for steering control and that is intended by the manufacturer for use on natural terrain. "Off-road motorcycle" includes a motorcycle that was originally issued a certificate of title and registered for highway use under Iowa Code chapter 321, but which contains design features that enable operation over natural terrain.

"Off-road utility vehicle" means a motorized flotation-tire vehicle with not less than four and not more than eight low-pressure tires that is limited in engine displacement to less than 1,500 cubic centimeters and in total dry weight to not more than 1,800 pounds and that has a seat that is of bucket or bench design, not intended to be straddled by the operator, and a steering wheel or control levers for control. A motorized vehicle that was previously titled or is currently titled under Iowa Code chapter 321 shall not be registered or operated as an off-road utility vehicle.

"Regulated vehicle" means all-terrain vehicles, off-road motorcycles, and off-road utility vehicles, either collectively or individually. For purposes of this chapter only, "regulated vehicle" shall also include a snowmobile.

"Snowmobile" means a motorized vehicle weighing less than 1,000 pounds which uses sled-type runners or skis, endless belt-type tread with a width of 48 inches or less, or any combination of runners, skis, or tread, and is designed for travel on snow or ice. "Snowmobile" does not include an all-terrain vehicle which has been altered or equipped with runners, skis, belt-type tracks, or treads.

"Vessel" means every description of watercraft, other than a seaplane, used or capable of being used as a means of transportation on water or ice. Ice boats are watercraft.

"Watercraft" means any vessel which through the buoyant force of water floats upon the water and is capable of carrying one or more persons. Docks, defined and regulated by 571—Chapter 16, are not watercraft.

[**ARC 8880B**, IAB 6/30/10, effective 8/4/10]

DIVISION I
ALL-TERRAIN VEHICLES, OFF-ROAD MOTORCYCLES, OFF-ROAD UTILITY VEHICLES AND SNOWMOBILES

571—50.2(321G,321I) Bond required before issuance of title or registration. If the county recorder or the department is not satisfied as to the ownership of the regulated vehicle or that there are no undisclosed security interests in the regulated vehicle, the recorder or the department shall require completion of the following procedures prior to issuing title and registration:

50.2(1) *Identification.* The applicant shall contact the department and provide identifying information in regard to the regulated vehicle. The required identifying information shall include the identification number and such additional information about the regulated vehicle as may be requested by the department. If no identification number is currently affixed to the regulated vehicle, the applicant shall complete the department's procedure for obtaining such number, and the assigned number shall be affixed before the applicant may proceed with the application process set forth in this chapter.

50.2(2) *Records search.* Upon receipt of sufficient identifying information from an applicant, the department shall:

a. Search the department's registration records to determine if there is an owner of record for the regulated vehicle and if the regulated vehicle has been reported stolen; and

b. Notify the applicant, orally or in writing, in regard to whether a record of prior ownership has been located and, if so, provide the name and last-known address of the owner of record.

50.2(3) *Examination.* At any time after being contacted by the applicant and before approval of an application, the department may examine the regulated vehicle.

50.2(4) *Notice to owner of record.* If the department finds a record of prior ownership in the department's registration records, the department shall provide the applicant with a bonding packet containing instructions that describe how to complete the bonding process. The packet shall include a notice to the owner of record and a certified mail envelope, return receipt requested, with a return address of the department. The notice shall state that the owner of record may assert the owner's right to claim the regulated vehicle. If neither the applicant nor the department receives a response from the owner of record within ten days after receipt of notice or the post office returns the notice to the applicant or the department as undeliverable or unclaimed, the department will continue processing the bond application.

50.2(5) *Submission of application.* To register the regulated vehicle, the applicant must submit the appropriate forms and fees described in 571—Chapter 46. In addition, the application shall include a statement obtained from an Iowa-registered dealer for the same type of regulated vehicle for which the value is being sought or documentation from the North American Dealers' Association indicating the current value of the regulated vehicle. In addition to the appropriate application form required under 571—Chapter 46, the following documents shall be submitted with the application form:

a. Photographs of the regulated vehicle which show the front, rear, and one side of the regulated vehicle.

b. The written ownership document received at the time that the regulated vehicle was acquired.

c. Satisfactory proof of the regulated vehicle identification number or DNR Form 542-8065. Examples of what constitutes satisfactory proof include, without limitation, corresponding photographs of the vehicle identification number and the vehicle or a readable pencil rubbing of the vehicle identification number.

d. The undeliverable or unclaimed certified letter and envelope addressed to the previous owner or the signed certified mail receipt, if available, if a record of prior ownership was located by the department.

e. A surety bond on DNR Form 542-8092 in an amount equal to one and one-half times the current value of the regulated vehicle, if required.

50.2(6) *Approval.* If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall forward the original application to the county recorder and notify the applicant that the regulated vehicle may be registered and titled in Iowa.

50.2(7) *Disapproval.* If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, that there is an unsatisfied security interest, or that the owner of record asserts a claim for the regulated vehicle, the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

[**ARC 8880B**, IAB 6/30/10, effective 8/4/10]

571—50.3 to **50.9** Reserved.

DIVISION II
VESSELS

571—50.10(462A) Bond required before issuance of title or registration. In the event the county recorder or the department is not satisfied as to the ownership of a vessel or that there are no undisclosed security interests in the vessel, the recorder or the department shall require completion of the following procedures prior to issuing title or registration:

50.10(1) *Identification.* The applicant shall contact the department and provide the department with identifying information in regard to the vessel. The required identifying information shall include the hull identification number, if applicable, and such additional information as may be requested by the

department. If no hull identification number is currently affixed on a vessel otherwise required by law to have a hull identification number, the applicant shall complete the department's procedure for obtaining such number, and the assigned number shall be affixed after the applicant has completed the registration and bonding process set forth in this chapter.

50.10(2) *Records search.* Upon receipt of sufficient identifying information from an applicant, the department shall:

a. Search the department registration records to determine if there is an owner of record for the vessel and if the vessel has been reported stolen; and

b. Notify the applicant, orally or in writing, in regard to whether a record of prior ownership has been located and, if so, provide the name and last-known address of the owner of record.

50.10(3) *Examination.* At any time after being contacted by the applicant and before approval of an application, the department may examine the vessel.

50.10(4) *Notice to owner of record.* If the department finds a record of prior ownership in the department's registration records, the department shall provide the applicant with a bonding packet containing instructions that describe how to complete the bonding process. The packet shall include a notice to the owner of record and a certified mail envelope, return receipt requested, with a return address of the department. The notice shall state that the owner of record may assert the owner's right to claim the vessel. If neither the applicant nor the department receives a response from the owner of record within ten days after receipt of notice or the post office returns the notice to the applicant or the department as undeliverable or unclaimed, the department will continue processing the bond application.

50.10(5) *Submission of application.* The applicant shall submit an application on DNR Form 542-8067. The form shall include a statement obtained from an Iowa-registered dealer for vessels or documentation from the North American Dealers' Association indicating the current value of the vessel. The following documents shall be submitted with the application form:

a. Photographs of the vessel which show the front, rear, and one side of the vessel.

b. The written ownership document received at the time that the vessel was acquired.

c. Satisfactory proof of the hull identification number or DNR Form 542-2000. Examples of what constitutes satisfactory proof include, without limitation, corresponding photographs of the hull identification number and the vessel or a readable pencil rubbing of the hull identification number.

d. The undeliverable or unclaimed certified letter and envelope addressed to the previous owner or the signed certified mail receipt, if available, if a record of prior ownership was located by the department.

e. A surety bond on DNR Form 542-8092 in an amount equal to one and one-half times the current value of the vessel.

50.10(6) *Approval.* If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall forward the original application to the county recorder and notify the applicant that the vessel may be registered and titled in Iowa.

50.10(7) *Disapproval.* If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, that there is an unsatisfied security interest, or that the owner of record asserts a claim for the vessel, the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

[**ARC 8880B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement Iowa Code sections 321G.21, 321G.29, 321I.22, 321I.31 and 462A.5A.

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CHAPTER 53
CONTROLLED HUNTING AREAS

[Prior to 12/31/86, Conservation Commission[290] Chs 14 and 15]

571—53.1(481A) Definitions.

"Commission" means the natural resource commission.

"Department" means the department of natural resources.

"Director" means the director of the department of natural resources or a designee.

571—53.2(481A) Waterfowl hunting on Forney Lake and Riverton Area. Rescinded IAB 9/4/02, effective 10/9/02.

571—53.3(481A) Waterfowl hunting on Lake Odessa. Rescinded IAB 6/30/10, effective 8/18/10.

These rules are intended to implement Iowa Code sections 481A.5, 481A.6, 481A.7, and 481A.48.

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CHAPTER 94
NONRESIDENT DEER HUNTING

571—94.1(483A) Licenses. Every hunter must have in possession a valid nonresident deer license, a valid nonresident hunting license, and proof that the hunter has paid the current year's wildlife habitat fee when hunting, possessing, or transporting deer. No person, while hunting deer, shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while deer hunting or tagging a deer.

94.1(1) *Types of licenses.*

a. Any-deer licenses. Any-deer licenses shall be valid for taking deer of either sex in the zone and season designated by the hunter when the application is submitted as described in rule 94.8(483A).

b. Mandatory antlerless-only licenses. Each hunter who is successful in drawing an any-deer license must also purchase an antlerless-only license for the same zone and season as the any-deer license. If the hunter is unsuccessful in drawing an any-deer license, neither the any-deer nor antlerless-only license will be issued.

c. Optional antlerless-only licenses. A hunter who is not successful in drawing an any-deer license may purchase an antlerless-only license as described in rule 571—94.8(483A).

d. Antlerless deer defined. Antlerless-only licenses shall be valid for taking deer that have no forked antler.

94.1(2) *Bow season license.* Bow and arrow deer licenses shall be valid for deer of either sex or antlerless deer during the bow season and in the zone designated by the hunter at the time the application is submitted.

94.1(3) *Regular gun season license.* Regular gun season licenses will be issued for deer of either sex or antlerless deer. Regular gun season licenses will be issued by zone and season and will be valid in the zone and season designated by the hunter when the application is submitted.

94.1(4) *Muzzleloader season license.* Muzzleloader season licenses will be issued for deer of either sex or antlerless deer and shall be valid only during the muzzleloader season and in the zone designated by the hunter when the application is submitted.

94.1(5) *Special licenses.* The commission shall issue licenses in conformance with Iowa Code section 483A.24(10) to nonresidents 21 years of age or younger who have a severe physical disability or who have been diagnosed with a terminal illness. A person applying for this license must provide a completed form obtained from the department of natural resources. The application shall be certified by the applicant's attending physician with an original signature and declare that the applicant has a severe physical disability or a terminal illness using the criteria listed in 571—Chapter 15. A medical statement from the applicant's attending physician that specifies criteria met shall be on 8½″ × 11″ letterhead stationery. The attending physician shall be a currently practicing doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner.

[**ARC 8252B**, IAB 11/4/09, effective 12/9/09]

571—94.2(483A) Season dates. Deer may be taken only during the following periods.

94.2(1) *Bow season.* Deer may be taken by bow and arrow only in accordance with the type and zone of license issued from October 1 through the Friday before the first Saturday in December, and from the Monday following the third Saturday in December through January 10 of the following year.

94.2(2) *Regular gun seasons.* Deer may be taken with gun only in accordance with the type, season, and zone of license issued, from the first Saturday in December and continuing for five consecutive days or from the second Saturday in December and continuing for nine consecutive days.

94.2(3) *Muzzleloader season.* Deer may be taken by muzzleloader only in accordance with the type and zone of license issued from the Monday following the third Saturday in December through January 10 of the following year.

571—94.3(483A) Shooting hours. Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

571—94.4(481A) Limits.

94.4(1) *Bow season.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

94.4(2) *Muzzleloader season.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

94.4(3) *Regular gun seasons.* The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

94.4(4) *Maximum annual possession limit.* The maximum annual possession limit for a nonresident deer hunter is one deer for each legal license and transportation tag obtained.

571—94.5(483A) Zones open to hunting. Licenses will be valid only in designated areas as follows:

94.5(1) *Zone descriptions.* The zones are described as areas bounded as follows:

a. *Zone 1.* Beginning at a point where U.S. Highway 169 crosses the Minnesota-Iowa state line; thence along U.S. Highway 169 to state Highway 3; thence along state Highway 3 to U.S. Highway 71; thence along U.S. Highway 71 to U.S. Highway 20; thence along U.S. Highway 20 to the Nebraska-Iowa state line; thence along the Nebraska-Iowa, South Dakota-Iowa and Minnesota-Iowa state lines to the point of beginning.

b. *Zone 2.* Beginning at the point where state Highway 3 and Interstate Highway 35 intersect; thence along Interstate Highway 35 to its eastern junction with Interstate Highways 80 and 235; thence along Interstate Highway 235 to its western junction with Interstate Highways 80 and 35; thence along Interstate Highway 80 to U.S. Highway 59; thence along U.S. Highway 59 to U.S. Highway 20; thence along U.S. Highway 20 to U.S. Highway 71; thence along U.S. Highway 71 to state Highway 3; thence along state Highway 3 to the point of beginning.

c. *Zone 3.* Beginning at the point where U.S. Highway 20 crosses the Nebraska-Iowa state line; thence along U.S. Highway 20 to U.S. Highway 59; thence along U.S. Highway 59 to the Missouri-Iowa state line; thence along the Missouri-Iowa and Nebraska-Iowa state lines to the point of beginning.

d. *Zone 4.* Beginning at the western junction of Interstate Highway 235 with Interstate Highways 80 and 35; thence along Interstate Highway 35 to the Missouri-Iowa state line; thence along the Missouri-Iowa state line to U.S. Highway 59; thence along U.S. Highway 59 to Interstate Highway 80; thence along Interstate Highway 80 to the point of beginning.

e. *Zone 5.* Beginning at the point where Interstate Highway 235 and state Highway 163 intersect; thence along state Highway 163 to state Highway 92; thence along state Highway 92 to U.S. Highway 218; thence along U.S. Highway 218 to U.S. Highway 34; thence along U.S. Highway 34 to U.S. Highway 63; thence along U.S. Highway 63 to the Missouri-Iowa state line; thence along the Missouri-Iowa state line to Interstate Highway 35; thence along Interstate Highway 35 to its western junction with Interstate Highways 80 and 235; thence along Interstate Highway 235 to the point of beginning.

f. *Zone 6.* Beginning at the point where U.S. Highway 63 crosses the Missouri-Iowa state line; thence along U.S. Highway 63 to U.S. Highway 34; thence along U.S. Highway 34 to U.S. Highway 218; thence along U.S. Highway 218 to state Highway 92; thence along state Highway 92 to the Illinois-Iowa state line; thence along the Illinois-Iowa and Missouri-Iowa state lines to the point of beginning.

g. *Zone 7.* Beginning at the point where U.S. Highway 61 intersects with state Highway 92 at its northern junction; thence along state Highway 92 to state Highway 163; thence along state Highway 163 to Interstate Highway 235; thence along Interstate Highway 235 to its eastern junction with Interstate Highways 80 and 35; thence along Interstate Highway 35 to state Highway 3; thence along state Highway

3 to state Highway 38; thence along state Highway 38 to U.S. Highway 61; thence along U.S. Highway 61 to the point of beginning.

h. *Zone 8.* Beginning at the point where state Highway 92 intersects with the Illinois-Iowa state line; thence along state Highway 92 to U.S. Highway 61; thence along U.S. Highway 61 to state Highway 38; thence along state Highway 38 to state Highway 3; thence along state Highway 3 to the Illinois-Iowa state line; thence along the Illinois-Iowa state line to the point of beginning.

i. *Zone 9.* Beginning at the point where state Highway 3 intersects with the Illinois-Iowa state line; thence along state Highway 3 to U.S. Highway 63; thence along U.S. Highway 63 to the Minnesota-Iowa state line; thence along the Minnesota-Iowa, Wisconsin-Iowa, and Illinois-Iowa state lines to the point of beginning.

j. *Zone 10.* Beginning at the point where U.S. Highway 63 crosses the Minnesota-Iowa state line; thence along U.S. Highway 63 to state Highway 3; thence along state Highway 3 to U.S. Highway 169; thence along U.S. Highway 169 to the Minnesota-Iowa state line; thence along the Minnesota-Iowa state line to the point of beginning.

94.5(2) *Closed areas.* There shall be no open season for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly.

571—94.6(483A) License quotas. A limited number of nonresident deer licenses will be issued in zones as follows:

94.6(1) *Zone license quotas.* Nonresident license quotas are as follows:

	Any-deer licenses		Mandatory Antlerless-only	Optional Antlerless-only
	All Methods	Bow		
Zone 1.	180	63	180	
Zone 2.	180	63	180	
Zone 3.	560	196	560	
Zone 4.	1280	448	1280	
Zone 5.	1600	560	1600	
Zone 6.	800	280	800	
Zone 7.	360	126	360	
Zone 8.	240	84	240	
Zone 9.	600	210	600	
Zone 10.	200	70	200	
Total	6000	2100	6000	3500

94.6(2) *Quota applicability.* The license quota issued for each zone will be the quota for all bow, regular gun and muzzleloader season licenses combined. No more than 6,000 any-deer licenses and 6,000 mandatory antlerless-only licenses will be issued for all methods of take combined, for the entire state. Of the 6,000 any-deer and 6,000 mandatory antlerless-only licenses, no more than 35 percent in any zone can be bow licenses. A maximum of 4,500 optional antlerless-only licenses will be issued on a county-by-county basis. The licenses will be divided between the counties in the same proportion as resident antlerless-only licenses. Hunters must designate a zone or county and season when purchasing the license and hunt only in that zone or county and season.

94.6(3) *Antlerless defined.* Rescinded IAB 3/1/06, effective 4/5/06.

[**ARC 7687B**, IAB 4/8/09, effective 5/13/09]

571—94.7(483A) Method of take. Permitted weapons and devices vary according to the type of season.

94.7(1) *Bow season.* Except for crossbows for persons with certain afflictions of the upper body, as provided in 571—15.5(481A), only longbow, compound or recurve bows shooting broadhead arrows are

permitted. Arrows must be at least 18 inches long. No explosive or chemical devices may be attached to the arrow or broadhead.

94.7(2) *Regular gun season.* Only 10-, 12-, 16-, or 20-gauge shotguns, shooting single slugs only, and flintlock or percussion cap lock muzzleloaded rifles or muskets of not less than .44 nor larger than .775 caliber, shooting single projectiles only, and handguns as described in 571—subrule 106.7(3), will be permitted in taking deer during the regular gun season.

94.7(3) *Muzzleloader and holiday seasons.* During the muzzleloader and holiday seasons, deer may be taken with a muzzleloader, handgun, or bow as described in 94.7(1). Muzzleloading rifles are defined as flintlock or percussion cap lock muzzleloaded rifles and muskets of not less than .44 and not larger than .775 caliber, shooting single projectiles only. Centerfire handguns must be .357 caliber or larger shooting straight-walled cartridges propelling an expanding-type bullet (no full-metal jacket) and complying with all other requirements provided in Iowa Code section 481A.48. Legal handgun calibers are listed on the department of natural resources list of "Acceptable Handgun Calibers for Hunting Deer in Iowa." Revolvers, pistols and black powder handguns must have a 4-inch minimum barrel length. There can be no shoulder stock or long-barrel modifications to handguns. Muzzleloading handguns must be .44 caliber or larger, shooting single projectiles only.

94.7(4) *Prohibited weapons and devices.* The use of dogs, domestic animals, salt or bait, rifles other than muzzleloaded, handguns except as provided in 94.7(3), crossbows except as provided in 571—15.5(481A), automobiles, aircraft, or any mechanical conveyances or device including electronic calls is prohibited except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt or mineral blocks or any other natural food materials, or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord.

It shall be unlawful for a person, while hunting deer, to have on their person a rifle other than a muzzleloading rifle that meets the requirements of 571—subrule 106.7(3).

94.7(5) *Discharge of firearms from highway.* No person shall discharge a shotgun shooting slugs or a rifle, including a muzzleloading rifle or musket, or a handgun from a highway during the regular gun seasons in all counties and parts of counties north of Highway 30. A "highway" means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

94.7(6) *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 94.2(2), unless such blind exhibits a solid blaze orange marking visible in all directions with a minimum height of 12 inches and a minimum width of 12 inches. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term "blind" is defined as a place of concealment constructed, either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

[**ARC 7687B**, IAB 4/8/09, effective 5/13/09; **ARC 8887B**, IAB 6/30/10, effective 8/18/10]

571—94.8(483A) Application procedure. Applications for nonresident deer hunting licenses must be made through the electronic licensing system for Iowa (ELSI) telephone order system or the ELSI Internet license sales Web site.

94.8(1) *Any-deer licenses.* Applications for any-deer and mandatory antlerless-only licenses will be accepted from the first Saturday in May through the first Sunday in June. No one may submit more than one application during the application period. Hunters may apply as individuals or as a group of up to 15 applicants. All members of a group will be accepted or rejected together in the drawing. If applications have been sold in excess of the license quota for any zone or season, a drawing will be held to determine which applicants receive licenses. Licenses or refunds of license fees will be mailed to applicants after the

drawing is completed. License agent writing fees, department administrative fees and telephone order charges will not be refunded. If any zone's license quota for any-deer and mandatory antlerless-only licenses has not been filled, the excess any-deer and mandatory antlerless-only licenses will be sold on a first-come, first-served basis through the telephone ordering system or the Internet license sales Web site. Excess any-deer and mandatory antlerless-only licenses will be sold beginning the last Saturday in July until the quota has been filled or the last day of the hunting period for which the license is valid, whichever occurs first. Members of a group that is rejected may purchase licenses individually if excess any-deer and mandatory antlerless-only licenses or optional antlerless-only licenses are available.

94.8(2) *Optional antlerless-only licenses.* Optional antlerless-only licenses must be purchased through the ELSI telephone ordering system or the ELSI Internet license sales Web site. Licenses for taking only antlerless deer will be available on the same date as excess any-deer licenses are sold as explained in 94.8(1). Optional antlerless-only licenses will only be issued for one of the two regular gun seasons and for qualified disabled hunters (571—94.10(481A)). They will be sold first-come, first-served until the county quota is filled, or until the last day of the season for which a license is valid. If optional antlerless-only licenses are still available on December 15, they may be purchased by nonresidents to hunt during the period from December 24 through January 2. These licenses will be available to nonresidents who have not purchased a nonresident deer license during one of the current deer seasons. The hunter must have in possession a valid nonresident small game hunting license and proof of having paid the current year's wildlife habitat fee. Optional antlerless-only licenses will be valid only in the season and county designated by the hunter at the time the license is purchased.

a. Nonresident landowners. Nonresidents who own land in Iowa will have preference in obtaining optional antlerless-only licenses. Nonresidents must qualify as landowners following the criteria stated in 571—subrule 106.12(1) and 571—subrules 106.12(3) through 106.12(6), except that nonresident tenants and family members of nonresident landowners and tenants do not qualify and nonresident optional antlerless-only licenses will not be free of charge. If a farm unit is owned jointly by more than one nonresident, only one owner may claim landowner preference in the same year. Nonresidents who own land jointly with a resident do not qualify for preference. Nonresidents who have provided proof to the department that they own land in Iowa and meet the qualifying criteria may purchase an optional antlerless-only license for one of the two regular gun seasons when excess any-deer licenses go on sale or for the holiday season beginning December 15. Such proof must be provided before an optional antlerless-only license can be purchased and must be resubmitted each year in which an optional antlerless-only license is purchased. These licenses do not count against the county quota.

b. Nonresident proof of land ownership. Nonresidents who request preference for optional antlerless-only licenses will be required to submit a copy of their state of Iowa property tax statement for the current year or sign an affidavit that lists the legal description of their land, date purchased, and book and page number, or instrument number, where the deed is recorded.

94.8(3) *Preference points.* Each individual applicant who is unsuccessful in the drawing for an any-deer license will be assigned one preference point for each year that the individual is unsuccessful. If a person who was unsuccessful in the drawing purchases a leftover license within four weeks, the person will receive a refund for the cost of the preference point. Preference points will not accrue in a year in which an applicant fails to apply, but the applicant will retain any preference points previously earned. Preference points will apply only to obtaining any-deer licenses. Once an applicant receives an any-deer nonresident deer hunting license, all preference points will be removed until the applicant is again unsuccessful in a drawing or purchases a preference point as described in subrule 94.8(4). Preference points will apply to any zone or season for which a hunter applies. The first drawing for any-deer licenses each year will be made from the pool of applicants with the most preference points. If licenses are still available after the first drawing, subsequent drawings will be made from pools of applicants with successively fewer preference points and continue until the any-deer license quota is reached or all applicants have received licenses. Applicants who apply as a group will be included in a pool of applicants with the same number of preference points as that of the member of the group with the fewest preference points assigned.

94.8(4) *Purchasing preference points.* A nonresident who does not want to hunt in the current year may purchase one preference point per calendar year. The preference point will apply to the next year's drawing for any-deer licenses. The preference point will be treated in the same manner as preference points obtained by hunters who are unsuccessful in the any-deer license drawing. A nonresident may not purchase a preference point and apply for an any-deer license in the same calendar year. Preference points may be purchased only during the application period for any-deer licenses.
[**ARC 8887B**, IAB 6/30/10, effective 8/18/10]

571—94.9(483A) Transportation tag. A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to the carcass of each deer, in such a manner that the tag cannot be removed without mutilating or destroying the tag, within 15 minutes of the time the deer is killed or before the carcass of the deer is moved in any manner, whichever first occurs. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to all deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility, or until the deer has been processed for consumption.

571—94.10(481A) Deer hunting season for severely disabled persons.

94.10(1) *Licenses.* A nonresident meeting the requirements of Iowa Code section 321L.1(8) may apply for or purchase a nonresident deer hunting license to participate in a special deer hunting season for severely disabled persons. Nonresidents applying for this license must have on file with the department of natural resources either a copy of a disabilities parking permit issued by a state department of transportation or an Iowa DNR form signed by a physician that verifies their disability.

94.10(2) *Season dates.* Any deer or antlerless deer may be taken in the hunting zone indicated on the deer license during 16 consecutive days beginning the third Saturday in September.

94.10(3) *Shooting hours.* Legal shooting hours will be from one-half hour before sunrise until one-half hour after sunset each day regardless of the type of weapon used.

94.10(4) *Limits.* Daily bag and possession limit is one deer. A person may shoot and tag only one deer by utilizing the license and tag issued in the person's name.

94.10(5) *License quotas.* Licenses for the special hunting season for severely disabled persons shall be issued from the quotas established in 571—94.6(483A). A special quota will not be set aside for severely disabled persons.

94.10(6) *Method of take and other regulations.* Deer may be taken with shotgun, bow, muzzleloading rifle or pistol as defined in 571—94.7(483A). All participants must meet the hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for taking deer with a gun or bow shall apply.

94.10(7) *Application procedures.* Persons meeting the requirements for this season must apply following the procedures described in 571—94.8(483A). A person who does not have a form on file to verify a disability will not be entered into the drawing or be allowed to purchase a license and will have the license fee refunded, less a $10 administrative fee to cover the cost of handling the application as provided in 571—subrule 15.11(1). License agent writing fees, department administrative fees, Internet sales charges and telephone order charges will not be refunded.

571—94.11(481A) Harvest reporting. Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

571—94.12(481A) January antlerless season. Beginning on January 11, nonresident hunters may obtain antlerless-only licenses for the January antlerless season specified in 571—subrule 106.2(5). Licenses will be available only in those counties specified in 571—subrule 106.6(4) until the quota provided in 571—subrule 106.6(6) is filled. All regulations specified in 571—Chapter 106 for the

January antlerless season for resident hunters including limits, shooting hours, method of take, tagging and reporting requirements will also apply to nonresident hunters during this season.
[**ARC 7687B**, IAB 4/8/09, effective 5/13/09]

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.1, 483A.8 and 483A.24.

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CHAPTER 106
DEER HUNTING BY RESIDENTS

[Prior to 12/31/86, Conservation Commission[290] Ch 106]

571—106.1(481A) Licenses. When hunting deer, all hunters must have in their possession a valid deer hunting license and a valid resident hunting license and must have paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person while hunting deer shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while that person is deer hunting or tagging a deer.

106.1(1) *Type of license.*

a. Any-deer licenses. Any-deer licenses shall be valid for taking deer of either sex in one season selected at the time the license is purchased. Paid any-deer licenses shall be valid statewide except where prohibited in deer population management zones established under 571—Chapter 105. Free any-deer licenses shall be valid only on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

b. Antlerless-deer-only licenses. Antlerless-deer-only licenses shall be valid for taking deer that have no forked antler. Paid antlerless-deer-only licenses shall be valid in one county or in one deer population management zone and in one season as selected at the time the license is purchased. Free and reduced-fee antlerless-deer-only licenses shall be valid on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

106.1(2) *Bow season licenses.* Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in both segments of the bow season.

106.1(3) *Regular gun season licenses.* Paid any-deer and antlerless-deer-only licenses shall be valid in either the first or the second regular gun season, as designated on the license. Free any-deer licenses and antlerless-deer-only licenses shall be valid in both the first and second regular gun seasons.

106.1(4) *Muzzleloader season licenses.* Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in either the early or the late muzzleloader season, as designated on the license.

106.1(5) *November antlerless-deer-only licenses.* Only antlerless-deer-only licenses, paid or free, will be issued for the November antlerless-deer-only season. Free antlerless-deer-only licenses shall be available only for the portion of the farm unit located in a county where paid antlerless-deer-only licenses are available during that season.

106.1(6) *January antlerless-deer-only licenses.* Only antlerless-deer-only licenses, paid or free, will be issued for the January antlerless-deer-only season. Free antlerless-deer-only licenses shall be available only in the portion of the farm unit located in a county where paid antlerless-deer-only licenses are available during that season.

106.1(7) *Free and reduced-fee deer licenses for landowners and tenants.* A maximum of one free any-deer license, two free antlerless-deer-only licenses, and two reduced-fee antlerless-deer-only licenses may be issued to a qualifying landowner or eligible family member and a qualifying tenant or eligible family member. Eligibility for licenses is described in 571—106.12(481A). The free any-deer license shall be available for one of the following seasons: the youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season or first and second regular gun seasons. One free antlerless-deer-only license shall be available for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, or November antlerless-deer-only season. The second free antlerless-deer-only license shall be valid only for the January antlerless-deer-only season and will be available only if a portion of the farm unit lies within a county where paid antlerless-deer-only licenses are available during that season. Each reduced-fee antlerless-deer-only license shall be valid for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, November antlerless-deer-only season or January antlerless-deer-only season. January antlerless-deer-only licenses will be available

only if a portion of the farm unit is located in a county where paid antlerless-deer-only licenses are available in that season.

106.1(8) *Antlerless-deer-only crossbow licenses for senior citizens.* Persons 70 years old or older may obtain one paid antlerless-deer-only license valid statewide for taking antlerless deer with a crossbow. The license will be valid only during the bow season.

106.1(9) *Nonambulatory deer hunting licenses.* The commission shall issue licenses in conformance with 2009 Iowa Acts, Senate File 187. A person applying for this license must provide a completed form obtained from the department of natural resources. The application shall be certified by the applicant's attending physician with an original signature and declare that the applicant is nonambulatory using the criteria listed in 2009 Iowa Acts, Senate File 187. A medical statement from the applicant's attending physician that specifies criteria met shall be on 8½″ × 11″ letterhead stationery. The attending physician shall be a currently practicing doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner.

[**ARC 7921B**, IAB 7/1/09, effective 8/5/09; **ARC 8255B**, IAB 11/4/09, effective 12/9/09; **ARC 8888B**, IAB 6/30/10, effective 8/18/10]

571—106.2(481A) Season dates. Deer may be taken only during the following seasons:

106.2(1) *Bow season.* Deer may be taken in accordance with the type of license issued from October 1 through the Friday before the first Saturday in December and from the Monday following the third Saturday in December through January 10 of the following year.

106.2(2) *Regular gun seasons.* Deer may be taken in accordance with the type, season and zone designated on the license from the first Saturday in December and continuing for five consecutive days (first regular gun season) or from the second Saturday in December and continuing for nine consecutive days (second regular gun season).

106.2(3) *Muzzleloader seasons.* Deer may be taken in accordance with the type, season and zone designated on the license from the Saturday closest to October 14 and continuing for nine consecutive days (early muzzleloader season) or from the Monday following the third Saturday in December through January 10 of the following year (late muzzleloader season).

106.2(4) *November antlerless-deer-only season.* Antlerless deer may be taken for three days beginning the Friday after Thanksgiving.

106.2(5) *January antlerless-deer-only season.* Antlerless deer may be taken from January 11 through the third following Sunday.

571—106.3(481A) Shooting hours. Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

571—106.4(481A) Limits.

106.4(1) *Bow season.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(2) *Muzzleloader seasons.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(3) *Regular gun seasons.* The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

106.4(4) *November antlerless-deer-only season.* The bag and possession limits and the tagging requirements are the same as for the regular gun seasons.

106.4(5) *January antlerless-deer-only season.* The daily bag and possession limit and the tagging requirements are the same as for the regular gun seasons.

106.4(6) *Maximum annual possession limit.* The maximum annual possession limit for a resident deer hunter is one deer for each legal license and transportation tag obtained.

571—106.5(481A) Areas closed to hunting. There shall be no open seasons for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly. There shall be no open seasons for hunting deer on all portions of rights-of-way on Interstate Highways 29, 35, 80 and 380.

571—106.6(481A) Paid deer license quotas and restrictions. Paid deer licenses, including antlerless-deer-only licenses, will be restricted in the type and number that may be purchased.

106.6(1) *Paid any-deer licenses.* Residents may purchase no more than two paid any-deer licenses, one for the bow season and one for one of the following seasons: early muzzleloader season, late muzzleloader season, first regular gun season, or second regular gun season. No more than 7,500 paid statewide any-deer licenses will be sold for the early muzzleloader season. Fifty additional paid early muzzleloader season licenses will be sold through and will be valid only for the Iowa Army Ammunition Plant. There will be no quota on the number of paid any-deer licenses issued in the bow season, late muzzleloader season, first regular gun season, or second regular gun season.

106.6(2) *Paid antlerless-deer-only licenses.* Paid antlerless-deer-only licenses have quotas for each county and will be sold for each county until quotas are reached.

a. Paid antlerless-deer-only licenses may be purchased for any season in counties where licenses are available, except as outlined in 106.6(2)*"b."* A license must be used in the season, county or deer population management area selected at the time the license is purchased.

b. No one may obtain paid licenses for both the first regular gun season and second regular gun season regardless of whether the licenses are valid for any deer or antlerless deer only. Paid antlerless-deer-only licenses for the early muzzleloader season may only be purchased by hunters who have already purchased one of the 7,500 paid statewide any-deer licenses.

c. Prior to September 15, a hunter may purchase one antlerless-deer-only license for any season for which the hunter is eligible. Beginning September 15, a hunter may purchase an unlimited number of antlerless-deer-only licenses for any season for which the hunter is eligible, as set forth in 106.6(2)*"b,"* until the county or population management area quotas are filled. Licenses purchased for deer population management areas will not count in the county quota.

106.6(3) *November antlerless-deer-only season.* Antlerless-deer-only licenses for the November antlerless-deer-only season shall be available in the following counties: Adair, Adams, Allamakee, Appanoose, Cass, Clarke, Clayton, Dallas, Davis, Decatur, Des Moines, Fayette, Fremont, Guthrie, Harrison, Henry, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Winneshiek, and Woodbury. Beginning the second Saturday prior to the opening of the November antlerless-deer-only season, an unlimited number of paid antlerless-deer-only licenses may be purchased for the November antlerless-deer-only season. These licenses may be obtained regardless of any other paid any-deer or paid antlerless-deer-only licenses that may have been obtained. Licenses will be sold until county quotas are filled. Licenses issued for this season are valid only on private property.

106.6(4) *January antlerless-deer-only licenses.* Antlerless-deer-only licenses for the January antlerless-deer-only season shall be available in the following counties: Adair, Adams, Allamakee, Appanoose, Cass, Clarke, Clayton, Dallas, Davis, Decatur, Des Moines, Fayette, Fremont, Guthrie, Harrison, Henry, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Winneshiek, and Woodbury. Beginning December 15, an unlimited number of paid antlerless-deer-only licenses may be purchased for the January antlerless-deer-only season. These licenses may be obtained regardless of any other paid any-deer or paid antlerless-deer-only licenses that may have been obtained.

106.6(5) *Free landowner/tenant licenses.* A person obtaining a free landowner/tenant license may purchase any combination of paid bow and paid gun licenses available to persons who are not eligible for landowner/tenant licenses as described in 571—106.12(481A).

106.6(6) *Antlerless-deer-only licenses.* Paid antlerless-deer-only licenses will be available by county as follows:

County	Quota	County	Quota	County	Quota
Adair	2400	Floyd	0	Monona	2500
Adams	1950	Franklin	0	Monroe	3000
Allamakee	4500	Fremont	1500	Montgomery	1300
Appanoose	3300	Greene	150	Muscatine	1700
Audubon	100	Grundy	0	O'Brien	0
Benton	1000	Guthrie	3300	Osceola	0
Black Hawk	0	Hamilton	100	Page	1800
Boone	650	Hancock	0	Palo Alto	0
Bremer	700	Hardin	200	Plymouth	100
Buchanan	250	Harrison	2500	Pocahontas	0
Buena Vista	0	Henry	2000	Polk	1500
Butler	0	Howard	350	Pottawattamie	2100
Calhoun	0	Humboldt	0	Poweshiek	650
Carroll	100	Ida	0	Ringgold	2600
Cass	1300	Iowa	1200	Sac	0
Cedar	1300	Jackson	1800	Scott	800
Cerro Gordo	0	Jasper	1700	Shelby	400
Cherokee	0	Jefferson	2150	Sioux	0
Chickasaw	450	Johnson	2000	Story	500
Clarke	2500	Jones	1500	Tama	650
Clay	0	Keokuk	1900	Taylor	2650
Clayton	5800	Kossuth	0	Union	2100
Clinton	1200	Lee	2500	Van Buren	5400
Crawford	300	Linn	1900	Wapello	2150
Dallas	2700	Louisa	1500	Warren	4200
Davis	3600	Lucas	2800	Washington	2250
Decatur	2800	Lyon	0	Wayne	3000
Delaware	1550	Madison	4000	Webster	100
Des Moines	2000	Mahaska	1350	Winnebago	0
Dickinson	0	Marion	2250	Winneshiek	3500
Dubuque	2000	Marshall	500	Woodbury	2500
Emmet	0	Mills	1350	Worth	0
Fayette	2500	Mitchell	0	Wright	0

[**ARC 7921B**, IAB 7/1/09, effective 8/5/09; **ARC 8888B**, IAB 6/30/10, effective 8/18/10]

571—106.7(481A) Method of take. Permitted weapons and devices vary according to the type of season.

106.7(1) *Bow season.* Only longbow, compound or recurve bows shooting broadhead arrows are permitted during the bow season. Arrows must be at least 18 inches long.

a. Crossbows may be used during the bow season in the following two situations:

(1) By persons with certain afflictions of the upper body as provided in 571—15.5(481A); and

(2) By persons over the age of 70 with an antlerless-deer-only license as provided in Iowa Code section 483A.8A.

b. No explosive or chemical devices may be attached to the arrow, broadhead or bolt (if used with a crossbow).

106.7(2) *Regular gun seasons.* Only 10-, 12-, 16- and 20-gauge shotguns shooting single slugs and muzzleloaders and handguns as described in 106.7(3) will be permitted for taking deer during the regular gun seasons.

106.7(3) *Muzzleloader seasons.* Only muzzleloading rifles and muzzleloading pistols will be permitted for taking deer during the early muzzleloader season. During the late muzzleloader season, deer may be taken with a muzzleloader, centerfire handgun, or bow as described in 106.7(1). Muzzleloading rifles are defined as flintlock or percussion cap lock muzzleloaded rifles and muskets of not less than .44 and not larger than .775 caliber, shooting single projectiles only. Centerfire handguns must be .357 caliber or larger shooting straight-walled cartridges propelling an expanding-type bullet (no full-metal jacket) and complying with all other requirements provided in Iowa Code section 481A.48. Legal handgun calibers are listed on the department of natural resources list of Acceptable Handgun Calibers for Hunting Deer in Iowa. Revolvers, pistols and black powder handguns must have a 4-inch minimum barrel length. There can be no shoulder stock or long-barrel modifications to handguns. Muzzleloading handguns must be .44 caliber or larger, shooting single projectiles only.

106.7(4) *November antlerless-deer-only season.* Bows, shotguns, muzzleloaders and handguns as described in this rule may be used.

106.7(5) *January antlerless-deer-only season.* Bows, shotguns, muzzleloaders and handguns as described in this rule may be used during the January antlerless-deer-only season. Centerfire rifles .24 caliber or larger may be used in the southern two tiers of counties.

106.7(6) *Prohibited weapons and devices.* The use of dogs, domestic animals, bait, rifles other than muzzleloaded or as provided in 106.7(5), handguns except as provided in 106.7(3), crossbows except as provided in 106.7(1), automobiles, aircraft, or any mechanical conveyance or device, including electronic calls, is prohibited, except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt, mineral blocks, or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord. It shall be unlawful for a person, while hunting deer, to carry or have in possession a rifle except as provided in 106.7(3) and 106.7(5). It shall be unlawful for a person hunting with a bow license to carry a handgun unless that person also has a valid deer hunting license and an unfilled transportation tag that permits a handgun to be used to take deer.

106.7(7) *Discharge of firearms from roadway.* No person shall discharge a rifle, including a muzzleloading rifle or musket, or a handgun from a highway while deer hunting. In addition, no person shall discharge a shotgun shooting slugs from a highway north of U.S. Highway 30. A "highway" means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

106.7(8) *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 106.2(3), unless such blind exhibits a solid blaze orange marking visible in all directions with a minimum height of 12 inches and a minimum width of 12 inches. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term "blind" is defined as a place of concealment constructed, either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

571—106.8(481A) Procedures to obtain licenses. All resident deer hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents, or online at www.iowadnr.com, or by calling the ELSI telephone ordering system.

106.8(1) *Licenses with quotas.* All paid deer hunting licenses for which a quota is established may be obtained from the ELSI system on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

106.8(2) *Licenses without quotas.* All deer hunting licenses that have no quota may be obtained from the ELSI system beginning August 15 through the last day of the hunting period for which a license is valid.

106.8(3) *Providing false information.*

a. Any person who provides false information about the person's identity or eligibility for any paid or free landowner/tenant deer license and tag and who attests that the information is correct by accepting and signing the license or tag shall have the person's hunting license revoked as a part of the sentencing for such criminal conviction, and the person shall not be issued a hunting license for one year pursuant to the authority of Iowa Code Supplement section 483A.24(2)*"f"* and rule 571—15.6(483A).

b. In addition to any legal penalties that may be imposed, the obtaining of a license in violation of this rule shall invalidate that deer license and transportation tag and any other deer hunting license and transportation tag obtained during the same year.

571—106.9(481A) Transportation tag. A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to the carcass of each deer in such a manner that the tag cannot be removed without mutilating or destroying the tag. This tag shall be attached to the carcass of the deer within 15 minutes of the time the deer is killed or before the carcass is moved in any manner, whichever occurs first. No person shall tag a deer with a transportation tag issued to another person. During the youth/disabled hunter season, bow season, early muzzleloader season and late muzzleloader season, the hunter who killed the deer must tag the deer by using the transportation tag issued in that person's name. During the first and second regular gun seasons and the November and January antlerless-deer-only seasons, anyone present in the hunting party may tag a deer with a tag issued in that person's name. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to the deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility or until the deer has been processed for consumption.

571—106.10(481A) Youth deer and severely disabled hunts.

106.10(1) *Licenses.*

a. *Youth deer hunt.* A youth deer license may be issued to any Iowa resident who is not over 15 years old on the day the youth obtains the license. The youth license may be paid or free to persons eligible for free licenses. If the youth obtains a free landowner/tenant license, it will count as the one free any-deer license for which the youth's family is eligible.

Each participating youth must be accompanied by an adult who possesses a regular hunting license and has paid the habitat fee (if the adult is normally required to have a hunting license and to pay the habitat fee to hunt). Only one adult may participate for each youth hunter. The accompanying adult must not possess a firearm or bow and must be in the direct company of the youth at all times.

A person may obtain only one youth any-deer license but may also obtain any other paid or free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner with which other hunters obtain them, as described in 106.6(2).

b. *Severely disabled hunt.* Any severely disabled Iowa resident meeting the requirements of Iowa Code section 321L.1(8) may be issued one any-deer license to hunt deer during the youth season. A person applying for this license must either possess a disability parking permit or provide a completed form from the department of natural resources. The form must be signed by a physician verifying that the person's disability meets the criteria defined in Iowa Code section 321L.1(8). Forms are available online at www.iowadnr.com, by visiting the DNR central office or any district office, or by calling (515)281-5918. A person between 16 and 65 years of age must also possess a regular hunting license and have paid the habitat fee to obtain a license (if normally required to have a hunting license and to pay

the habitat fee to hunt). A severely disabled person obtaining this license may obtain any other paid and free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner by which other hunters obtain them, as described in 106.6(2).

106.10(2) *Season dates.* Deer of either sex may be taken statewide for 16 consecutive days beginning on the third Saturday in September. A person who is issued a youth deer hunting license and does not take a deer during the youth deer hunting season may use the deer hunting license and unused tag during the early muzzleloader, late muzzleloader, and one of the shotgun seasons. The license will be valid for the type of deer and in the area specified on the original license. The youth must follow all other rules specified in this chapter for each season. A youth hunting in one of the other seasons must obtain a hunting license and habitat stamp or hunt with a licensed adult if required by Iowa Code section 483A.24. If the tag is filled during one of the seasons, the license will not be valid in subsequent seasons.

106.10(3) *Shooting hours.* Legal shooting hours will be one-half hour before sunrise to one-half hour after sunset each day regardless of weapon used.

106.10(4) *Limits and license quotas.* An unlimited number of licenses may be issued. The daily and season bag and possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.10(5) *Method of take and other regulations.* Deer may be taken with shotgun, bow or muzzleloaded rifles as permitted in 571—106.7(481A). All participants must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for obtaining licenses or hunting deer shall apply.

106.10(6) *Procedures for obtaining licenses.* Paid and free youth season licenses and licenses for severely disabled hunters may be obtained through ELSI beginning August 15 through the last day of the youth season.

571—106.11(481A) Deer depredation management. The deer depredation management program provides assistance to producers through technical advice and additional deer licenses and permits where the localized reduction of female deer is needed to reduce damage. Upon signing a depredation management agreement with the department, producers of agricultural or high-value horticultural crops may be issued deer depredation permits to shoot deer causing excessive crop damage. If immediate action is necessary to forestall serious damage, depredation permits may be issued before an agreement is signed. Further permits will not be authorized until an agreement is signed.

106.11(1) *Method of take and other regulations.* Legal weapons and restrictions will be governed by 571—106.7(481A). For deer shooting permits only, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93. The producer or designee must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122.

106.11(2) *Eligibility.* Producers growing typical agricultural crops (such as corn, soybeans, hay and oats and tree farms and other forestlands under a timber management program) and producers of high-value horticultural crops (such as Christmas trees, fruit or vegetable crops, nursery stock, and commercially grown nuts) shall be eligible to enter into depredation management agreements if these crops sustain excessive damage.

a. The producer may be the landowner or a tenant, whoever has cropping rights to the land.

b. Excessive damage is defined as crop losses exceeding $1,000 in a single growing season, or the likelihood that damage will exceed $1,000 if preventive action is not taken, or a documented history of at least $1,000 of damage annually in previous years.

c. Producers who lease their deer hunting rights are not eligible for the deer depredation management program.

106.11(3) *Depredation management plans.* Upon request from a producer, field employees of the wildlife bureau will inspect and identify the type and amount of crop damage sustained from deer. If damage is not excessive, technical advice will be given to the producer on methods to reduce or prevent

future damage. If damage is excessive and the producer agrees to participate, a written depredation management plan will be developed by depredation biologists in consultation with the producer.

a. The goal of the management plan will be to reduce damage to below excessive levels within a specified time period through a combination of producer-initiated preventive measures and the issuance of deer depredation permits.

(1) Depredation plans written for producers of typical agricultural crops may require preventive measures such as harassment of deer with pyrotechnics and cannons, guard dogs, and temporary fencing, as well as allowing more hunters, increasing the take of antlerless deer, and other measures that may prove effective.

(2) Depredation plans written for producers of high-value horticultural crops may include all of the measures in (1) above, plus permanent fencing where necessary. Fencing will not be required if the cost of a fence exceeds $1,000.

(3) Depredation permits to shoot deer may be issued to Iowa residents to reduce deer numbers until long-term preventive measures become effective. Depredation permits will not be used as a long-term solution to deer damage problems.

b. Depredation management plans will normally be written for a three-year period with progress reviewed annually by the department and the producer.

(1) The plan will become effective when signed by the depredation biologist and the producer.

(2) Plans may be modified or extended if mutually agreed upon by the department and the producer.

(3) Depredation permits will not be issued after the initial term of the management plan if the producer fails to implement preventive measures outlined in the plan.

106.11(4) *Depredation permits.* Two types of permits may be issued under a depredation management plan.

a. Deer depredation licenses. Deer depredation licenses may be sold to resident hunters only for the regular deer license fee for use during one or more legal hunting seasons. Depredation licenses will be available to producers of agricultural and horticultural crops.

(1) Depredation licenses will be issued up to the number specified in the management plan.

(2) The landowner or an eligible family member, which shall include the landowner's spouse or domestic partner and juvenile children, may obtain one depredation license for each season established by the commission. No other individual may initially obtain more than three depredation licenses per management plan. When a deer is reported harvested on one of these licenses, then another license may be obtained.

(3) Depredation licenses will be valid only for hunting antlerless deer, regardless of restrictions that may be imposed on regular deer hunting licenses in that county.

(4) Hunters may keep any deer legally tagged with a depredation license.

(5) All other regulations for the hunting season specified on the license will apply.

(6) Depredation licenses will be valid only on the land where damage is occurring and the immediately adjacent property unless the land is within a designated block hunt area as described in subparagraph (7). Other parcels of land in the farm unit not adjacent to the parcels receiving damage will not qualify.

(7) Block hunt areas are areas designated and delineated by wildlife biologists of the wildlife bureau to facilitate herd reduction in a given area where all producers may not qualify for the depredation program or in areas of persistent deer depredation. Depredation licenses issued to producers within the block hunt area are valid on all properties within the delineated boundaries. Individual landowner permission is required for hunters utilizing depredation licenses within the block hunt area boundaries. Creation of a given block hunt area does not authorize trespass.

b. Deer shooting permits. Permits for shooting deer outside an established hunting season may be issued to producers of high-value horticultural crops when damage cannot be controlled in a timely manner during the hunting seasons (such as late summer buck rubs in an orchard and winter browsing in a Christmas tree plantation) and to other agricultural producers who have an approved DNR deer depredation plan, and on areas such as airports where public safety may be an issue.

(1) Deer shooting permits will be issued at no cost to the applicant.

(2) The applicant or one or more designees approved by the department may take all the deer specified on the permit.

(3) Permits available to producers of high-value horticultural crops or agricultural crops may be valid for taking deer outside of a hunting season depending on the nature of the damage. The number and type of deer to be killed will be determined by a department depredation biologist and will be part of the deer depredation management plan.

(4) Permits issued due to public safety concerns may be used for taking any deer, as necessary, to address unpredictable intrusion which could jeopardize public safety. Permits may be issued for an entire year (January 1 through December 31) if the facility involved signs an agreement with the department.

(5) All deer killed must be recovered and processed for human consumption.

(6) The times, dates, place and other restrictions on the shooting of deer will be specified on the permit.

(7) Antlers from all deer recovered must be turned over to the conservation officer within 48 hours. Antlers will be disposed of according to department rules.

(8) For out-of-season shooting permits, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93.

c. Depredation licenses and shooting permits will be issued in addition to any other licenses for which the hunters may be eligible.

d. Depredation licenses and shooting permits will not be issued if the producer restricts the legal take of deer from the property sustaining damage by limiting hunter numbers below levels required to control the deer herd. This restriction does not apply in situations where shooting permits are issued for public safety concerns.

e. A person who receives a depredation permit pursuant to this paragraph shall pay a $1 fee for each license that shall be used and is appropriated for the purpose of deer herd population management, including assisting with the cost of processing deer donated to the help us stop hunger (HUSH) program administered by the commission and a $1 writing fee for each license to the license agent.

106.11(5) *Disposal.* Rescinded IAB 7/16/08, effective 8/20/08.

[**ARC 7921B**, IAB 7/1/09, effective 8/5/09]

571—106.12(481A) Eligibility for free landowner/tenant deer licenses.

106.12(1) *Who qualifies for free deer hunting licenses.*

a. Owners and tenants of a farm unit and the spouse and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free deer licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

b. Juvenile child defined. "Juvenile child" means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

106.12(2) *Who qualifies as a tenant.* A "tenant" is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner's family, including in some circumstances the landowner's spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

106.12(3) *What "actively engaged in farming" means.* Landowners and tenants are "actively engaged in farming" if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

106.12(4) *Landowners who qualify as active farmers.* These landowners:

a. Are the sole operator of a farm unit (along with immediate family members), or

b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or

c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or

d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or

e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or

f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

106.12(5) *Landowners who do not qualify.* These landowners:

a. Use a farm manager or other third party to operate the farm, or

b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

106.12(6) *Where free licenses are valid.* A free license is valid only on that portion of the farm unit that is in a zone open to deer hunting. "Farm unit" means all parcels of land in tracts of two or more contiguous acres that are operated as a unit for agricultural purposes and are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. "Agricultural purposes" includes but is not limited to field crops, livestock, horticultural crops (e.g., from nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

106.12(7) *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free deer hunting licenses must register with the department before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

571—106.13(481A) Harvest reporting. Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

571—106.14(481A) Extension to the regular gun seasons. Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.24, and 483A.24B and 2009 Iowa Acts, Senate File 187.

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CHAPTER 108
MINK, MUSKRAT, RACCOON, BADGER, OPOSSUM, WEASEL, STRIPED SKUNK, FOX (RED AND GRAY), BEAVER, COYOTE, RIVER OTTER, BOBCAT, GRAY (TIMBER) WOLF AND SPOTTED SKUNK SEASONS

[Prior to 12/31/86, Conservation Commission[290] Ch 104]

571—108.1(481A) Mink, muskrat and weasel. Open season for the taking of mink, muskrat and weasel shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

108.1(1) *Molesting or disturbing muskrat houses.* Any department of natural resources officer, natural resource biologist, or county conservation board director may permit trappers to molest or disturb muskrat houses on specific state or county game management areas as provided in Iowa Code section 481A.90, after finding that muskrats are causing excessive damage by destroying the vegetation essential to the welfare of a marsh and after so posting the area.

108.1(2) *Game management areas.* Open season for taking muskrats on certain state game management areas, certain federal national wildlife refuges, and certain county conservation board areas, only where approved by the wildlife bureau and posted accordingly, shall be from 8 a.m. the day after the regular muskrat trapping season ends until April 1. The use of leg-hold traps during this season is prohibited unless each trap is placed completely inside a muskrat house. No bag or possession limit.

[**ARC 7933B**, IAB 7/1/09, effective 8/5/09]

571—108.2(481A) Raccoon, badger, opossum and striped skunk. Open season for the taking of raccoon, badger, opossum, and striped skunk shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.3(481A) Red and gray fox. Open season for the taking of red and gray fox shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.4(481A) Beaver. Open season for the taking of beaver shall be from 8 a.m. on the first Saturday in November through April 1 of succeeding year. No bag or possession limit.

571—108.5(481A) Coyote.

108.5(1) *Hunting.* Continuous open season. Entire state open. No bag or possession limit.

108.5(2) *Trapping.* Open season for trapping coyote shall be 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit. Any conservation officer or wildlife biologist may authorize a landowner, tenant or designee to trap coyotes causing damage outside the established trapping season dates.

571—108.6(481A) Gray (timber) wolf and spotted skunk. Continuous closed season.

571—108.7(481A) River otter and bobcat.

108.7(1) *License requirements.* Each person who takes river otters or bobcats shall have a valid fur harvester license and pay the habitat fee if normally required to have a license to hunt or trap.

108.7(2) *Open area.* River otters may be taken statewide. Bobcats may be taken in the following counties: Adair, Adams, Appanoose, Cass, Clarke, Davis, Decatur, Des Moines, Fremont, Guthrie, Harrison, Henry, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, and Woodbury.

108.7(3) *Quotas and seasonal bag limit.*

a. *Seasonal bag limit.* The seasonal bag limit is 2 river otters and 1 bobcat per person.

b. *Quotas.* The quota for the number of river otters that may be taken is 500 statewide. The quota for the number of bobcats that may be taken is 250 in the open area. The season shall end for river otters

when the number of river otters trapped, as determined by the harvest reporting system, reaches 500. The season shall end for bobcats when the number of bobcats taken, as determined by the harvest reporting system, reaches 250. Trappers shall be allowed a 48-hour grace period after the quota is reached to clear their traps of river otters or bobcats. River otters or bobcats found in traps during the grace period may be kept even though the quota is exceeded provided that the trapper has not reached the trapper's personal bag limit. River otters or bobcats trapped after the grace period or in excess of the seasonal bag limit must be turned over to the department; the trapper shall not be penalized.

108.7(4) *Season dates.* The season for taking river otters and bobcats opens on the first Saturday in November and closes when the quota has been reached, as explained in this rule, or on January 31 of the following year, whichever occurs first.

108.7(5) *Reporting requirements.*

a. Anyone, including a landowner or tenant not required to have a fur harvester license, who takes a river otter or bobcat must report the harvest to a DNR conservation officer or designated DNR employee within 24 hours. The fur harvester must arrange to receive a CITES tag from the officer or designated DNR employee within 48 hours of the time the harvest is reported or before the river otter or bobcat is skinned, whichever occurs first.

b. Upon receiving a telephone report that a river otter or bobcat has been legally taken, the conservation officer or DNR employee will call the department's harvest reporting system. The number of river otters and bobcats taken will be updated daily, and a message will be recorded on the department's telephone system. The number taken will be available 24 hours a day. Fur harvesters may check the message daily to determine when the season closes and when the grace period begins and ends. The department will use all practical means to publicize these dates.

108.7(6) *Tagging requirements.* Every river otter or bobcat that may legally be kept must have a CITES tag attached. Tags will be supplied by the conservation officer or designated DNR employee. The tag must remain with the pelt until the pelt is sold or used for other purposes that render it no longer available for sale. Persons displaying river otters or bobcats as taxidermy mounts or as other decorative items must keep the tags in their possession as proof of legal harvest.

[**ARC 7933B**, IAB 7/1/09, effective 8/5/09; **ARC 8889B**, IAB 6/30/10, effective 8/18/10]

571—108.8(481A) Accidental capture of a river otter or bobcat during a closed season. A person who accidentally captures a river otter or bobcat during a closed season or in a closed area or after the person's individual bag limit has been reached shall not be penalized provided that:

1. The river otter or bobcat is captured during a legal trapping season or as part of a legal depredation control process; and

2. A conservation officer is contacted within 24 hours and the river otter or bobcat and all parts thereof are turned over to a conservation officer as soon as practical.

571—108.9(481A) Trapping restrictions. Trapping for all furbearers will be restricted as follows:

108.9(1) *Exposed bait.* No person shall set or maintain any leghold, body-clasping trap, or snare within 20 feet of exposed bait on land anywhere in the state or over water in the following areas:

a. Mississippi River corridor—Allamakee, Clayton, Dubuque, Jackson, Clinton, Scott, Muscatine, Louisa, Des Moines and Lee Counties.

b. Missouri River corridor—Those portions of Woodbury, Monona, Harrison, Pottawattamie, Mills and Fremont Counties west of Interstate 29.

c. Des Moines River corridor—Boone, Dallas, Polk, Marion, Mahaska, Wapello and Van Buren Counties.

Exposed bait means meat or viscera or any animal, bird, fish, amphibian, or reptile with or without skin, hide, or feathers visible to soaring birds.

108.9(2) *Trapping near beaver lodges and dens.* Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.6, 481A.38, 481A.39, 481A.87, and 481A.90.

These rules are based on the best biological data available as determined by research conducted by the department of natural resources.

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PROFESSIONAL LICENSURE DIVISION[645]

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

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CHAPTER 300
LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

645—300.1(147) Definitions. For purposes of these rules, the following definitions shall apply:

"Active license" means a license that is current and has not expired.

"ASHA" means the American Speech-Language Hearing Association.

"Assistant" means a person who works under the supervision of an Iowa-licensed speech pathologist or audiologist, does not meet the requirements to be licensed as a speech pathologist or audiologist, and meets the minimum requirements set forth in these rules.

"Audiologist" means a person who engages in the application of principles, methods and procedures for measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, rehabilitation, or remediation related to disorders of hearing and associated communication disorders for the purpose of nonmedically evaluating, identifying, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals, including the determination and use of appropriate amplification.

"Board" means the board of speech pathology and audiology.

"Full-time" means a minimum of 30 hours per week.

"Grace period" means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may included licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Licensee" means any person licensed to practice as a speech pathologist or audiologist in the state of Iowa.

"License expiration date" means December 31 of odd-numbered years.

"Licensure by endorsement" means the issuance of an Iowa license to practice speech pathology or audiology to an applicant who is or has been licensed in another state.

"On site" means:

1. To be continuously on site and present in the department or facility where services are being provided;
2. To be immediately available to assist the person being supervised in the services being performed; and
3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated.

"Reactivate" or *"reactivation"* means the process as outlined in rule 300.17(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice speech pathology or audiology to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of speech pathology and audiology to license persons that have the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

"Speech pathologist" means a person who engages in the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, rehabilitation, or remediation related to the development and disorders of speech, fluency, voice, or language for the purpose of nonmedically evaluating, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals.

645—300.2(147) Speech pathology and audiology services subject to regulation. The provision of speech pathology or audiology services in Iowa through telephonic, electronic, or other means, regardless of the location of the speech/language pathologist or audiologist, shall constitute the practice of speech pathology or audiology and shall require Iowa licensure.

645—300.3(147) Requirements for licensure. The following criteria shall apply to licensure:

300.3(1) The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the board office. All applications shall be sent to Board of Speech Pathology and Audiology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

300.3(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

300.3(3) Each application shall be accompanied by the appropriate fees payable to the Board of Speech Pathology and Audiology. The fees are nonrefundable.

300.3(4) The application shall include:

a. An official copy of a current American Speech-Language Hearing Association (ASHA) certificate of clinical competence; or

b. Submission of the following:

(1) Official copies of academic transcripts sent directly from the school to the board showing proof of possession of a master's degree in speech pathology or a master's or doctoral degree in audiology or the equivalent of one of these degrees and official verification of completion of not less than 400 hours of supervised clinical training;

(2) Verification of nine months of full-time clinical experience, or equivalent, completed after the master's degree, under the supervision of a licensed speech pathologist or audiologist or as a part of the doctoral degree; and

(3) Results of the National Teacher Examination.

300.3(5) Licensees who were issued their licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal date two years later.

300.3(6) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

645—300.4(147) Educational qualifications.

300.4(1) The applicant shall possess the following:

a. A master's degree from an accredited school, college or university with a major in speech pathology; or

b. A master's or doctoral degree from an accredited school, college or university with a major in audiology.

300.4(2) Foreign-trained speech pathologists and audiologists shall:

a. Provide an equivalency evaluation of their educational credentials by one of the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665, telephone (310)258-9451, Web site www.ierf.org or E-mail at info@ierf.org; International Credentialing Associates, Inc., 7245 Bryan Dairy Road, Bryan Dairy Business Park II, Largo, FL 33777, telephone (727)549-8555. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a speech pathology or audiology program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

645—300.5(147) Examination requirements. The examination required by the board shall be the National Teacher Examination in speech pathology or audiology. This examination is administered by the Educational Testing Service. The applicant should contact the nearest accredited college or university for the time and place of the examination.

300.5(1) The applicant has full responsibility for making arrangements to take the National Teacher Examination in speech pathology or audiology and for bearing all expenses associated with taking the examination. The applicant also has the responsibility for having the examination scores sent directly to the board from the Educational Testing Service.

300.5(2) The board shall determine the qualifying scores for both the speech pathology and audiology examinations.

645—300.6(147) Temporary clinical license. A temporary clinical license for the purpose of obtaining clinical experience as a prerequisite for licensure is valid for one year and may be renewed at the discretion of the board.

300.6(1) A speech pathology applicant must submit the following to the board:

a. Evidence of supervision by a speech pathologist with an active, current Iowa license in good standing;

b. An official application form provided by the board and completed by the applicant;

c. An official copy of the transcript, sent directly from the school to the board, showing proof of possession of a master's degree in speech pathology;

d. Official verification of completion of not less than 400 hours of supervised clinical training in an accredited college or university;

e. The temporary clinical license fee; and

f. Results of the National Teacher Examination.

300.6(2) An audiology applicant or an applicant completing a doctoral externship must submit the following to the board:

a. Evidence of supervision by an audiologist with an active, current Iowa license in good standing. The applicant completing an audiology doctoral externship must show evidence of on-site supervision;

b. An official application form provided by the board and completed by the applicant;

c. An official copy of the transcript, sent directly from the school to the board, showing proof of possession of a master's degree in audiology;

d. Official verification of completion of not less than 400 hours of supervised clinical training in an accredited college or university;

e. The temporary clinical license fee; and

f. Results of the National Teacher Examination.

300.6(3) The plan for supervised clinical experience must be approved by the board before the applicant starts practice and shall:

a. Include at least nine months of full-time clinical experience, or equivalent;

b. Include supervision by an Iowa-licensed speech pathologist or audiologist, as appropriate. If the applicant is being supervised by more than one individual, each supervisor must submit a supervised clinical experience plan for approval. If there is a change in the supervised clinical experience plan at any

time during the supervised clinical experience, the licensee must contact the board for approval within 30 days of the change;

c. Be kept by the supervisor for two years from the last date of the clinical experience; and

d. Include a completed supervised clinical experience report form that shall be submitted to the board of speech pathology and audiology upon the applicant's successful completion of the nine months of full-time clinical experience. If the applicant was supervised by more than one individual, each supervisor must submit a supervised clinical experience report. The applicant may then apply for licensure.

[**ARC 8872B**, IAB 6/30/10, effective 8/4/10]

645—300.7(147) Temporary permit.

300.7(1) A nonresident may apply to the board for a temporary permit to practice speech pathology or audiology:

a. For a period not to exceed three months;

b. By submitting a letter to support the need for such a permit;

c. By submitting documents to show that the applicant has substantially the same qualifications as required for licensure in Iowa;

d. By submitting the documentation prior to the date the applicant intends to begin practice; and

e. By submitting the temporary permit fee.

300.7(2) The applicant shall receive a final determination from the board regarding the application for a temporary permit.

645—300.8(147) Use of assistants. A licensee shall, in the delivery of professional services, utilize assistants only to the extent provided in these rules.

300.8(1) *Duties.*

a. *Speech pathology assistant I.* A speech pathology assistant I works with an individual for whom significant improvement is expected within a reasonable amount of time.

b. *Speech pathology assistant II.* A speech pathology assistant II works with an individual for whom maintenance of present level of communication is the goal; or for whom, based on the history and diagnosis, only slow improvement is expected.

c. *Audiology assistant I.* An audiology assistant I is more broadly trained and may be given a variety of duties depending upon the individual's training.

d. *Audiology assistant II.* An audiology assistant II is trained specifically for a single task for screening.

300.8(2) *Minimum requirements.*

a. A speech pathology assistant I or II or audiology assistant I must satisfy the following minimum requirements:

(1) Reach the age of majority;

(2) Complete a high school education, or its equivalent; and

(3) Complete one of the following:

1. A three-semester-hour (or four-quarter-hour) course in introductory speech and language pathology for speech pathology assistants or in audiology for audiology assistants from an accredited educational institution and 15 hours of instruction in the specific tasks which the assistant will be performing; or

2. A minimum training period comprised of 75 clock hours on instruction and practicum experience.

b. An audiology assistant II must satisfy the following requirements:

(1) Reach the age of majority.

(2) Complete a high school education, or its equivalent.

(3) Complete a minimum of 15 clock hours of instruction and practicum experience in the specific task which the assistant will be performing.

300.8(3) *Utilization.* Utilization of a speech pathology or audiology assistant requires that a plan be developed by the licensee desiring to utilize that assistant, consisting of the following information:

a. Documentation that the assistant meets minimum requirements;

b. A written plan of the activities and supervision that must be kept by the licensee supervising the assistant. This supervision must include direct on-site observation for a minimum of 20 percent of the assistant's direct patient care for level I speech pathology and level I audiology assistants and 10 percent for level II speech pathology assistants. Level II audiology assistants must be supervised 10 percent of the time. At least half of that time must be direct on-site observation with the other portion provided as time interpreting results;

c. A listing of the facilities where the assistant will be utilized; and

d. A statement, signed by the licensee and the assistant, that the rules pertaining to assistants have been read by both.

300.8(4) *Maximum number of assistants.* A licensee may not utilize more than three assistants unless a plan of supervision is filed and approved by the board.

300.8(5) *Supervisor responsibilities.* A licensee who utilizes an assistant shall have the following responsibilities:

a. To be legally responsible for the actions of the assistant in that assistant's performance of assigned duties with a client;

b. To make all professional decisions relating to the management of a client;

c. To ensure that the assistant is assigned only those duties and responsibilities for which the assistant has been specifically trained and is qualified to perform;

d. To ensure compliance of the assistant(s) under supervision with the provisions of these rules by providing periodic direct observation and supervision of the activities of the assistant; and

e. To submit to the board of speech pathology and audiology upon request a copy of the plan of activities and supervision for each assistant and documentation of the dates each assistant was utilized by the licensee.

645—300.9(147) Licensure by endorsement. An applicant who has been a licensed speech pathologist or audiologist under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

1. Submits to the board a completed application;
2. Pays the licensure fee;
3. Shows evidence of a current ASHA certificate or at least nine months of full-time clinical experience or its equivalent;
4. Shows evidence that the National Teacher Examination scores have been sent directly from the examination service to the board;
5. Provides official copies of the academic transcripts; and
6. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- Licensee's name;
- Date of initial licensure;
- Current licensure status; and
- Any disciplinary action taken against the license.

645—300.10(147) Licensure by reciprocal agreement. Rescinded IAB 6/30/10, effective 8/4/10.

645—300.11(147) License renewal.

300.11(1) The biennial license renewal period for a license to practice speech pathology or audiology shall begin on January 1 of an even-numbered year and end on December 31 of the next odd-numbered year. The board shall send a renewal notice by regular mail to each licensee at the address on record

at least 60 days prior to expiration of the license. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of the responsibility for renewing the license.

300.11(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal date two years later.

300.11(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—303.2(147) and the mandatory reporting requirements of subrule 300.11(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

300.11(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirements as identified in paragraph *"e."*

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

Training may be completed through separate courses as identified in paragraphs *"a"* and *"b"* or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs *"a"* to *"c,"* including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 303.

f. The board may select licensees for audit of compliance with the requirements in paragraphs *"a"* to *"e."*

300.11(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

300.11(6) A person licensed to practice as a speech pathologist or audiologist shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

300.11(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule

305.1(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

300.11(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a speech pathologist or audiologist in Iowa until the license is reactivated. A licensee who practices as a speech pathologist or audiologist in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

645—300.12(272C) Exemptions for inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—300.13(272C) Lapsed licenses. Rescinded IAB 9/14/05, effective 10/19/05.

645—300.14(147) Duplicate certificate or wallet card. Rescinded IAB 6/30/10, effective 8/4/10.

645—300.15(147) Reissued certificate or wallet card. Rescinded IAB 6/30/10, effective 8/4/10.

645—300.16(17A,147,272C) License denial. Rescinded IAB 6/30/10, effective 8/4/10.

645—300.17(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

300.17(1) Submit a reactivation application on a form provided by the board.

300.17(2) Pay the reactivation fee that is due as specified in 645—Chapter 305.

300.17(3) Provide verification of current competence to practice speech pathology and audiology by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 30 hours of continuing education within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 60 hours of continuing education within two years of application for reactivation; or

(3) Verification of passing the National Teacher Examination (NTE) for Speech Pathology or Audiology within the last two years prior to application for reactivation.

645—300.18(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 300.17(17A,147,272C) prior to practicing speech pathology and audiology in this state.

These rules are intended to implement Iowa Code chapters 17A, 147 and 272C.

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◊ Two or more ARCs

CHAPTER 303
CONTINUING EDUCATION FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

645—303.1(147) Definitions. For the purpose of these rules, the following definitions shall apply:

"AAA" means the American Association of Audiology.

"Active license" means a license that is current and has not expired.

"Approved program/activity" means a continuing education program/activity meeting the standards set forth in these rules.

"ASHA" means the American Speech-Language Hearing Association.

"Audit" means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

"Board" means the board of speech pathology and audiology.

"Continuing education" means planned, organized learning acts designed to maintain, improve, or expand a licensee's knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

"Hour of continuing education" means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Independent study" means a subject/program/activity that a person pursues autonomously that meets standards for approval criteria in the rules and includes a posttest.

"License" means license to practice.

"Licensee" means any person licensed to practice speech pathology or audiology or both in the state of Iowa.

645—303.2(147) Continuing education requirements.

303.2(1) The biennial continuing education compliance period shall extend for a two-year period between January 1 of each even-numbered year and December 31 of each odd-numbered year. Each biennium, each person who is licensed to practice as a speech pathology or audiology licensee in this state shall be required to complete a minimum of 30 hours of continuing education approved by the board. A person holding licensure in both speech pathology and audiology must meet the requirements for each profession.

303.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 30 hours of continuing education per biennium for each subsequent license renewal.

303.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

303.2(4) No hours of continuing education shall be carried over into the next biennium except as stated for second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

303.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

645—303.3(147,272C) Standards.

303.3(1) *General criteria.* A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date(s), location, course title, presenter(s);

(2) Number of program contact hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

303.3(2) *Specific criteria.*

a. Subject matters that integrally relate to the practice of speech pathology or audiology or both that will be considered for approval are:

(1) Basic communication processes. Information (beyond the basic licensure requirements) applicable to the normal development and use of speech, language, and hearing, i.e., anatomic and physiologic bases for the normal development and use of speech, language, and hearing; physical bases and processes of the production and perception of speech, language, and hearing; linguistic and psycholinguistic variables related to normal development and use of speech, language, and hearing; and technological, biomedical, engineering, and instrumentation information which would enable expansion of knowledge in the basic communication processes. Any computer course used for continuing education must involve the actual application to the communicatively impaired population.

(2) Professional areas. Information pertaining to disorders of speech, language, and hearing, i.e., various types of disorders of communication, their manifestations, classification and causes; evaluation skills, including procedures, techniques, and instrumentation for assessment; and management procedures and principles in habilitation and rehabilitation of communication disorders. The board shall accept dysphagia courses provided by qualified instructors.

(3) Related areas. Study pertaining to the understanding of human behavior, both normal and abnormal, as well as services available from related professions which apply to the contemporary practice of speech-language pathology/audiology, e.g., theories of learning and behavior; services available from related professions that also deal with persons who have disorders of communication; information from these professions about the sensory, physical, emotional, social or intellectual states of child or adult; and other areas such as general principles of program management, professional ethics, clinical supervision, counseling and interviewing.

Unacceptable subject matter includes personal development, human relations, collective bargaining, and tours. While desirable, these subjects are not applicable to the licensees' skill, knowledge and competence as expressed in Iowa Code section 272C.2, paragraph *"g."* Such courses will receive no credit toward the minimum 30 hours required for license renewal.

b. A licensee may elect to take the National Teacher Examination in speech pathology or audiology in lieu of earning continuing education credits. The licensee shall have the results of the examination sent to the board by the agency administering the examination.

c. Independent study.

(1) The maximum number of hours for independent study is 16 hours.

(2) Criteria for presentations are as follows:

1. A maximum of 10 hours of the maximum 16 hours of independent study credit will be given for presenting professional programs that meet the criteria as listed in rule 303.3(147,272C).

2. Two hours of credit will be awarded for each hour of new presentation material.

3. A course schedule or brochure must be maintained for audit.

d. A combined total of six hours per biennium may be used for the following activities:

(1) Government regulations;

(2) CPR, child abuse and dependent adult abuse; and

(3) A maximum of two hours may be used for business-related topics.

e. An applicant shall provide official transcripts indicating successful completion of academic courses which apply to the field of speech pathology and audiology in order to receive the following continuing education credits:

1 academic semester hour = 15 continuing education hours of credit

1 academic trimester hour = 12 continuing education hours of credit

1 academic quarter hour = 10 continuing education hours of credit

645—303.4(147,272C) Audit of continuing education report. Rescinded IAB 6/30/10, effective 8/4/10.

645—303.5(147,272C) Automatic exemption. Rescinded IAB 6/30/10, effective 8/4/10.

645—303.6(147,272C) Continuing education exemption for disability or illness. Rescinded IAB 6/30/10, effective 8/4/10.

645—303.7(147,272C) Grounds for disciplinary action. Rescinded IAB 6/30/10, effective 8/4/10.

645—303.8(147,272C) Continuing education exemption for inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—303.9(147,272C) Continuing education waiver for disability or illness. Rescinded IAB 9/14/05, effective 10/19/05.

645—303.10(147,272C) Reinstatement of inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—303.11(272C) Hearings. Rescinded IAB 9/14/05, effective 10/19/05.

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CHAPTER 304
DISCIPLINE FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

[Prior to 9/9/87, see Health Department [470], Ch 156]
[Prior to 9/19/01, see 645—Chapter 301]

645—304.1(147) Definitions.

"Board" means the board of speech pathology and audiology.

"Discipline" means any sanction the board may impose upon licensees.

"Licensee" means a person licensed to practice as a speech pathologist or audiologist in Iowa.

645—304.2(272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—304.3(272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

304.2(1) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, the following:

a. An intentional perversion of the truth in making application for a license to practice in this state;

b. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state; or

c. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

304.2(2) Professional incompetency. Professional incompetency includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other speech pathologists or audiologists in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average speech pathologist or audiologist acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a licensed speech pathologist or audiologist in this state.

304.2(3) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

304.2(4) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

304.2(5) Practice outside the scope of the profession.

304.2(6) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee's ability to practice with reasonable skill or safety.

304.2(7) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

304.2(8) Falsification of client records.

304.2(9) Acceptance of any fee by fraud or misrepresentation includes, but is not limited to, billing for services which were not rendered or charging fees which are inconsistent with any prior agreements reached with the clients.

304.2(10) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care, including negligent delegation

of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

304.2(11) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

304.2(12) Violation of a regulation, rule, or law of this state, another state, or the United States, which relates to the practice of speech pathology or audiology.

304.2(13) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory, or country; or failure of the licensee to report such action within 30 days of the final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report shall be expunged from the records of the board.

304.2(14) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the individual's practice of speech pathology or audiology in another state, district, territory or country.

304.2(15) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

304.2(16) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

304.2(17) Engaging in any conduct that subverts or attempts to subvert a board investigation.

304.2(18) Failure to comply with a subpoena issued by the board or failure to cooperate with an investigation of the board.

304.2(19) Failure to respond within 30 days of receipt of communication from the board which was sent by registered or certified mail.

304.2(20) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

304.2(21) Failure to pay costs assessed in any disciplinary action.

304.2(22) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

304.2(23) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

304.2(24) Knowingly aiding, assisting, or advising a person to unlawfully practice speech pathology or audiology.

304.2(25) Failure to report a change of name or address within 30 days after it occurs.

304.2(26) Representing oneself as a licensed speech pathologist or audiologist when one's license has been suspended or revoked, or when one's license is on inactive status.

304.2(27) Permitting another person to use the licensee's license for any purpose.

304.2(28) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license.

304.2(29) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but is not limited to, the following:

a. Verbally or physically abusing a client or coworker.

b. Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a client or coworker.

c. Betrayal of a professional confidence.

d. Engaging in a professional conflict of interest.

e. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

304.2(30) Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

304.2(31) Violation of the following code of ethics:

a. Claims of expected clinical results shall be based upon sound evidence and shall accurately convey the probability and degree of expected improvement.

b. Records shall be adequately maintained for the period of time required by applicable state and federal laws.

c. Persons served professionally or the files of such persons will be used for teaching or research purposes only after obtaining informed consent from those persons or from the legal guardians of such persons.

d. Information of a personal or professional nature obtained from persons served professionally will be released only to individuals authorized by the persons receiving professional service or to those individuals to whom release is required by law.

e. Relationships between professionals and between a professional and a client shall be based on high personal regard and mutual respect without concern for race, religious preference, sex, or age.

f. Referral of clients for additional services or evaluation and recommendation of sources for purchasing appliances shall be without any consideration for financial or material gain to the licensee making the referral or recommendation for purchase.

g. Licensees who dispense products to persons served professionally shall provide clients with freedom of choice for the source of services and products.

h. Failure to comply with current Food and Drug Administration regulations 21 CFR §801.420, "Hearing aid devices; professional and patient labeling," and 21 CFR §801.421, "Hearing aid devices, conditions for sale."

304.2(32) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[**ARC 8872B**, IAB 6/30/10, effective 8/4/10]

645—304.3(272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the licensee's engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed $1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—304.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care for the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;

6. Whether remedial action has been taken; and

7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—304.5(147) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 1/14/09, effective 2/18/09.

These rules are intended to implement Iowa Code chapters 147 and 272C.

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MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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[Prior to 5/4/88, see 470—135.251 to 470—135.402]

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

13.1(2) A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

653—13.2(148,272C) Standards of practice—appropriate pain management. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of adjunct therapies such as acupuncture, physical therapy and massage in the treatment of acute and chronic pain. This rule focuses on prescribing and administering controlled substances to provide relief and eliminate suffering for patients with acute or chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.
2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.
3. The board recognizes that pain management, including the use of controlled substances, is an important part of general medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.
4. Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.
5. The board recognizes that the undertreatment of pain is a serious public health problem that results in decreases in patients' functional status and quality of life, and that adequate access by patients to proper pain treatment is an important objective of any pain management policy.
6. Inappropriate pain management may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(1) *Definitions.* For the purposes of this rule, the following terms are defined as follows:

"Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"Addiction" means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"Chronic pain" means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain.

"Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

"Physical dependence" means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

"Substance abuse" means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

"Tolerance" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Undertreatment of pain" means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(2) *Laws and regulations governing controlled substances.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations governing controlled substances.

13.2(3) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use controlled substances for terminal pain due to the physician's concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(4) *Assessment and treatment of acute pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute pain. Acute pain is not a diagnosis; it is a symptom. Prescribing controlled substances for the treatment of acute pain should be based on clearly diagnosed and documented pain. Appropriate management of acute pain should include an assessment of the mechanism, type and intensity of pain. The patient's medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

13.2(5) *Effective management of chronic pain.* Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a

patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral. A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, or other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Physician-patient agreements. A physician treating patients with controlled substances or opiates shall consider establishing physician-patient agreements that specify the rules for medication use and the consequences for misuse. In preparing an agreement, a physician shall evaluate the case of each patient on its own merits, taking into account the nature of the risks to the patient and the potential benefits of treatment.

h. *Substance abuse history or comorbid psychiatric disorder.* A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. *Termination of care.* The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(6) *Pain management for terminal illness.* The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opiates or controlled substances to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(7) *Pain management resources.* The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. In March 2007, the Washington State Agency Medical Directors' Group published an educational pilot to improve care and safety of patients with chronic, noncancer pain who are treated with opioids. The guidelines include opioid dosing recommendations.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

653—13.3(147) Supervision of pharmacists who administer adult immunizations. A physician may prescribe adult immunizations via written protocol for influenza and pneumococcal vaccines for administration by an authorized pharmacist if the physician meets these requirements for supervising the pharmacist.

13.3(1) *Definitions.*

a. *"Authorized pharmacist"* means an Iowa-licensed pharmacist who has documented that the pharmacist has successfully completed an Accreditation Council for Pharmacy Education (ACPE)-approved continuing pharmaceutical education program on vaccine administration that:

(1) Requires documentation by the pharmacist of current certification in the American Heart Association or the Red Cross Basic Cardiac Life Support Protocol for health care providers;

(2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current Centers for Disease Control and Prevention guidelines, and provides instruction and experiential training in the following content areas:

1. Standards for immunization practices;
2. Basic immunology and vaccine protection;
3. Vaccine-preventable diseases;
4. Recommended immunization schedules;
5. Vaccine storage and management;
6. Informed consent;
7. Physiology and techniques for vaccine administration;
8. Pre- and post-vaccine assessment and counseling;
9. Immunization record management; and
10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. *"Vaccine"* means a specially prepared antigen which, upon administration to a person, will result in immunity and, specifically for the purposes of this rule, shall mean influenza and pneumococcal vaccines.

c. *"Written protocol"* means a physician's order for one or more patients that contains, at a minimum, the following:

(1) A statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of administration of adult immunizations for influenza and pneumococcus;

(2) A statement identifying the individual authorized pharmacist;

(3) A statement that forbids an authorized pharmacist from delegating the administration of adult immunizations to anyone other than another authorized pharmacist, a registered pharmacist-intern under the direct personal supervision of the authorized pharmacist, or a registered nurse;

(4) A statement identifying the vaccines that may be administered by an authorized pharmacist, the dosages, and the route of administration;

(5) A statement identifying the activities an authorized pharmacist shall follow in the course of administering adult immunizations, including:

1. Procedures for determining if a patient is eligible to receive the vaccine;
2. Procedures for determining the appropriate scheduling and frequency of drug administration in accordance with applicable guidelines;
3. Procedures for record keeping and long-term record storage including batch or identification numbers;
4. Procedures to follow in case of life-threatening reactions; and
5. Procedures for the pharmacist and patient to follow in case of reactions following administration;

(6) A statement that describes how the authorized pharmacist shall report the administration of adult immunizations, within 30 days, to the physician issuing the written protocols and to the patient's primary care physician, if one has been designated by the patient. In case of serious complications, the authorized pharmacist shall notify the physicians within 24 hours and submit a VAERS report to the bureau of immunizations, Iowa department of public health. (VAERS is the Vaccine Advisory Event Reporting System.) A serious complication is one that requires further medical or therapeutic intervention to effectively protect the patient from further risk, morbidity, or mortality.

13.3(2) *Supervision.* A physician who prescribes adult immunizations to an authorized pharmacist for administration shall adequately supervise that pharmacist. Physician supervision shall be considered adequate if the delegating physician:

a. Ensures that the authorized pharmacist is prepared as described in subrule 13.3(1), paragraph *"a"*;

b. Provides a written protocol that is updated at least annually;

c. Is available through direct telecommunication for consultation, assistance, and direction, or provides physician backup to provide these services when the physician supervisor is not available;

d. Is an Iowa-licensed physician who has a working relationship with an authorized pharmacist within the physician's local provider service area.

13.3(3) *Administration of other adult immunizations by pharmacists.* A physician may prescribe, for an individual patient by prescription or medication order, other adult immunizations to be administered by an authorized pharmacist.

This rule is intended to implement Iowa Code sections 147.76 and 272C.3.

653—13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management. A supervising physician may only delegate aspects of drug therapy management to an authorized pharmacist pursuant to a written protocol with a pharmacist pursuant to the requirements of this rule. The physician is considered the supervisor and retains the ultimate responsibility for the care of the patient. The authorized pharmacist retains full responsibility for proper execution of pharmacy practice.

13.4(1) *Definitions.*

"Authorized pharmacist" means an Iowa-licensed pharmacist who meets the training requirements of the Iowa board of pharmacy (IBP) as specified in the drug therapy management criteria in 657—8.34(155A).

"Board" means the board of medicine of the state of Iowa.

"Collaborative drug therapy management" means participation by a physician and an authorized pharmacist in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

"Collaborative practice" means that a physician may delegate aspects of drug therapy management for the physician's patients to an authorized pharmacist through a written community practice protocol. "Collaborative practice" also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and the hospital's clinic patients through a hospital practice protocol when the clinic and the pharmacist are under the direct authority of the hospital's P&T committee.

"Community practice protocol" means a written, executed agreement entered into voluntarily between a physician and an authorized pharmacist establishing drug therapy management for one or more of the physician's patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 13.4(2).

"Community setting" means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

"Hospital clinic" means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

"Hospital pharmacist" means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital's P&T committee.

"Hospital practice protocol" means a written plan, policy, procedure, or agreement that authorizes drug therapy management between physicians and hospital pharmacists within a hospital and its clinics as developed and determined by its P&T committee. Such a protocol may apply to all physicians and hospital pharmacists at a hospital or the hospital's clinics under the direct authority of the hospital's P&T committee or only to those physicians and pharmacists who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 13.4(3).

"IBP" means the Iowa board of pharmacy.

"P&T committee" means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

"Physician" means a person who is currently licensed in Iowa to practice medicine and surgery or osteopathic medicine and surgery. A physician who executes a written protocol with an authorized pharmacist shall supervise the pharmacist's activities involved in the overall management of patients receiving medications or disease management services under the protocol. The physician may delegate only drug therapies that are in areas common to the physician's practice.

"Therapeutic interchange" means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

13.4(2) *Community practice protocol.*

a. A physician shall engage in collaborative drug therapy management with a pharmacist only under a written protocol that is identified by topic and has been submitted to the IBP or a committee authorized by the IBP. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

b. The community practice protocol shall include:

(1) The name, signature, date and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a particular patient. If more than one authorized pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal pharmacist shall be designated in the protocol.

(2) The name, signature, date and contact information for each physician who may prescribe drugs and is responsible for supervising a patient's drug therapy management. The physician who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal physician.

(3) The name and contact information of the principal physician and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

(4) A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration and route of administration of the drug authorized by the patient's physician. The protocol shall not authorize the pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the patient's physician for follow-up.

4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

(5) Procedures for the physician to secure the patient's written consent. If the physician does not secure the patient's written consent, the pharmacist shall secure such and notify the patient's physician within 24 hours.

(6) Circumstances that shall cause the pharmacist to initiate communication with the physician, including but not limited to the need for new prescription orders and reports of the patient's therapeutic response or adverse reaction.

(7) A detailed statement identifying the specific drugs, laboratory tests and physical findings upon which the pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy protocol to be reviewed, updated and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist's decisions or recommendations for the physician.

(10) A description of the types of reports the physician requires the pharmacist to provide and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame in which a pharmacist shall report any adverse reaction to the physician.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits a physician from delegating collaborative drug therapy management to any unlicensed or licensed person other than another physician or authorized pharmacist.

(17) A description of the mechanism for the pharmacist and physician to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

c. Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least the patient's physician and one authorized pharmacist.

d. A collaborative drug therapy management protocol must be filed with the IBP, kept on file in the pharmacy and made available to the board or IBP upon request. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

e. A physician may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the physician notifies, in writing, the pharmacist and the IBP. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. After July 1, 2008, the physician shall no longer be required to notify the IBP of changes in the protocol.

f. Patient consent for community practice protocols. The physician or pharmacist who initiates a protocol with a patient is responsible for securing a patient's written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient needs to be communicated to the other party at the time of securing the patient's consent. The patient's physician shall maintain the patient consent in the patient's medical record.

13.4(3) *Hospital practice protocol.*

a. A hospital's P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by its hospital pharmacists in the hospital and its clinics. Hospital clinics are restricted to outpatient care clinics operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

b. Collaborative drug therapy management within a hospital setting or the hospital's clinic setting is valid only when approved by the hospital's P&T committee.

c. The hospital practice protocol shall include:

(1) The names or groups of physicians and pharmacists who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency,

duration and route of administration of the drug authorized by the physician. The protocol shall not authorize the hospital pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the physician for follow-up.

(4) Circumstances that shall cause the hospital pharmacist to initiate communication with the patient's physician, including but not limited to the need for new medication orders and prescription drug orders and reports of a patient's therapeutic response or adverse reaction.

(5) A statement of the medication categories and the type of initiation and modification of drug therapy that the protocol authorizes the hospital pharmacist to perform.

(6) A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

(7) A description of the mechanism for the hospital pharmacist and the patient's physician to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

This rule is intended to implement Iowa Code chapter 148.

653—13.5(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147 and 148.

653—13.6(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.6(1) An internal quality control assurance plan shall include the following elements:

a. The name of the physician responsible for the internal quality assurance plan and testing;

b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;

c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;

d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;

e. Staff training and qualifications for dispensing via the dispensing system;

f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;

g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;

h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;

i. A plan for interval testing of the accuracy of dispensing, at least annually; and

j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.6(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.6(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph *"i."*

653—13.7(147,148,272C) Standards of practice—office practices.

13.7(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.7(2) *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

13.7(3) *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.7(4) *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor, regardless of whether the patient consents to that conduct.

13.7(5) *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.7(6) *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature which interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.7(7) *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.7(8) *Retention of medical records.* The following paragraphs become effective on January 1, 2004.

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Upon a physician's death or retirement, the sale of a medical practice or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

653—13.8 Reserved.

653—13.9(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.9(1) *Definition.* As used in this rule:

"Interventional chronic pain management" means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

13.9(2) *Interventional chronic pain management.* The practice of interventional chronic pain management shall include the following:

a. Comprehensive assessment of the patient;

b. Diagnosis of the cause of the patient's pain;

c. Evaluation of alternative treatment options;

d. Selection of appropriate treatment options;

e. Termination of prescribed treatment options when appropriate;

f. Follow-up care; and

g. Collaboration with other health care providers.

13.9(3) *Practice of medicine.* Interventional chronic pain management is the practice of medicine.

[**ARC 8918B**, IAB 6/30/10, effective 8/4/10]

653—13.10(17A,147,148,272C) Waiver or variance prohibited. Renumbered as 653—13.21(17A,147,148,272C), IAB 12/24/03, effective 1/28/04.

653—13.11 to **13.19** Reserved.

653—13.20(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association shall be utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.20(1) *Conflict of interest.* A physician should not provide medical services under terms or conditions which tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.20(2) *Fees.* Any fee charged by a physician shall be reasonable.

653—13.21(17A,147,148,272C) Waiver or variance prohibited. Rules in this chapter are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

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[1] Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

CHAPTER 14
IOWA PHYSICIAN HEALTH COMMITTEE

653—14.1(272C) Iowa physician health committee. Pursuant to the authority of Iowa Code section 272C.3(1)*"k,"* the board establishes the Iowa physician health committee, formerly known as the impaired physician review committee.

653—14.2(272C) Definitions.

"Board" means the board of medicine of the state of Iowa.

"Health contract" or *"contract"* means the written document executed by an applicant or licensee and the IPHC which establishes the terms for participation in the Iowa physician health program.

"Impairment" means an inability, or significant potential for inability, to practice with reasonable safety and skill as a result of alcohol or drug abuse, dependency, or addiction, or any mental or physical disorder or disability. For the purposes of this program, "impairment" does not include sexual dysfunction, sexual addiction, sexual compulsivity, paraphilia, or other sexual disorder.

"Initial Agreement" means the written document establishing the initial terms for participation in the Iowa physician health program.

"IPHC" or *"committee"* means the Iowa physician health committee.

"IPHP" or *"program"* means the Iowa physician health program.

"Referral by the board" means the board has determined, with or without having taken disciplinary action, that the applicant or licensee is an appropriate candidate for participation in the IPHP pursuant to 653—14.11(272C).

"Self-report" means an applicant's or a licensee's providing written notification to the IPHC that the applicant or the licensee has been, is, or may be impaired. Information related to an impairment or a potential impairment which is provided on a license application or renewal form may be considered a self-report upon the request of the applicant or licensee and authorization from the board and agreement by the IPHC.

[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

653—14.3(272C) Purpose. The IPHC assists and monitors the recovery, rehabilitation, or maintenance of licensees who self-report impairments or are referred by the board pursuant to 653—14.11(272C) and, as necessary, notifies the board in the event of noncompliance with contract provisions. The IPHC is both an advocate for licensees' health and a means to protect the health and safety of the public.

[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

653—14.4(272C) Organization of the committee. The board shall appoint the members of the IPHC.

14.4(1) *Membership.* The membership of the IPHC includes, but is not limited to:

a. The executive director of the board or the director's designee from the board's staff;

b. One physician who has remained free of addiction for a period of no less than two years following successful completion of a board-approved recovery program, a board-ordered probation for alcohol or drug abuse, dependency, or addiction, or an IPHC contract;

c. One practitioner with expertise in substance abuse/addiction treatment programs;

d. One psychiatrist; and

e. One public member.

14.4(2) *Officers.* The committee shall elect a chairperson and vice chairperson at the last meeting of each calendar year to begin serving a one-year term on January 1.

14.4(3) *Terms.* Committee members, except the executive director, shall be appointed for three-year terms, for a maximum of three terms. Terms shall expire on December 31 of the third year of the term.

653—14.5(272C) Eligibility. To be eligible for participation in the IPHP, an applicant or a licensee must self-report an impairment or suspected impairment directly to the IPHP or be referred by the board for an impairment or suspected impairment pursuant to 653—14.11(272C) and be determined by the IPHC to be an appropriate candidate for participation in the IPHP.

14.5(1) An applicant's or licensee's participation in the program does not divest the board of its authority or jurisdiction over the applicant or licensee. An applicant or licensee with an impairment or suspected impairment as defined at 653—14.2(272C) may retain eligibility to participate in the program if appropriate while subject to investigation or discipline by the board for matters other than the alleged impairment.

14.5(2) An applicant or a licensee may be determined to be ineligible to participate in the program as a self-reporter or a referral from the board if the committee finds sufficient evidence of any of the following:

a. The applicant or licensee provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the committee.

b. The applicant or licensee fails to sign a contract when recommended by the committee.

c. The IPHC determines it will be unable to assist the applicant or licensee.

14.5(3) The IPHC shall report to the board any knowledge of violations of administrative rules or statutes other than the impairment.

[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

653—14.6(272C) Type of program. The IPHP is an individualized recovery, rehabilitation, or maintenance program designed to meet the specific needs of the impaired licensee. The committee, in consultation with an IPHC-approved evaluator, shall determine the type of recovery, rehabilitation, or maintenance program required to treat the applicant's or licensee's impairment. The committee shall prepare a health contract, to be signed by the applicant or licensee, that shall provide a detailed description of the goals of the program, the requirements for successful participation, and the applicant's or licensee's obligations therein.

653—14.7(272C) Terms of participation. A licensee or an applicant shall agree to comply with the terms for participation in the IPHP established in the initial agreement and contract. Terms of participation specified in the contract shall include, but are not limited to:

14.7(1) *Duration.* The length of time an applicant or a licensee may participate in the program shall be determined by the committee in accordance with the following:

a. Participation in the program for applicants or licensees impaired as a result of alcohol or drug dependency or addiction is set at a minimum of five years. The committee may offer a contract with a shorter duration to an applicant or licensee who can demonstrate successful participation in another state's physician health program, who can document similar experience, or who, as a board referral, has successfully completed a portion of the monitoring period established in the board order.

b. Length of participation in the program for applicants or licensees with impairments resulting from mental or physical disorders or disabilities will vary depending upon the recommendations provided by an approved evaluator and the determination of the IPHP following review of all relevant information.

14.7(2) *Noncompliance.* A licensee or an applicant participating in the program is responsible for notifying the committee of any instance of noncompliance including, but not limited to, a relapse. Notification of noncompliance made to the IPHP by the applicant or licensee, any person responsible for providing or monitoring treatment, or another party shall result in the following:

a. *First instance.* Upon receiving notification of a first instance of noncompliance including, but not limited to, a relapse, the IPHP shall make a report to the board which identifies the applicant or licensee by IPHP number, describes the relevant terms of the applicant's or licensee's contract and the nature of the noncompliance and includes recommendations as to whether the applicant or licensee should be allowed to remain in the program or whether formal disciplinary charges should be filed by the board.

b. *Second instance.* Upon receiving notification of a second instance of noncompliance including, but not limited to, a relapse, the IPHP shall nullify the contract and refer the case to the board for the filing of formal charges or other appropriate action.

14.7(3) *Practice restrictions.* The IPHP may impose restrictions on the license to practice the applicable profession as a term of the initial agreement or contract until such time as it receives a

report from an approved evaluator and the IPHC determines, based on all relevant information, that the licensee is capable of practicing with reasonable skill and safety. As a condition of participation in the program, a licensee is required to agree to restrict practice in accordance with the terms specified in the initial agreement or contract. In the event that the licensee or applicant refuses to agree to or comply with the restrictions established in the initial agreement or contract, the committee shall refer the applicant or licensee to the board for appropriate action.
[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

653—14.8(272C) Limitations.

14.8(1) The IPHC establishes the terms of and monitors a participant's compliance with the program specified in the initial agreement and contract. The IPHC is not responsible for participants who fail to comply with the terms of the initial agreement or contract or who fail to otherwise successfully complete the IPHP.

14.8(2) An applicant's or licensee's participation in the program shall not relieve the board of any duties and shall not divest the board of any authority or jurisdiction otherwise provided. An applicant or licensee who violates a statute or administrative rule of the board which is unrelated to impairment shall be referred to the board in accordance with these administrative rules for appropriate action.

653—14.9(272C) Confidentiality. Information in the possession of the board or the committee shall be subject to the confidentiality requirements of Iowa Code section 272C.6. Information about applicants or licensees in the program shall not be disclosed except as provided in this rule.

14.9(1) The IPHC is authorized pursuant to Iowa Code section 272C.6(4) to communicate information about an IPHP participant to the applicable regulatory authorities or impaired licensee programs of any jurisdiction of the United States or foreign nations in which the participant is currently licensed to practice medicine or in which the participant seeks licensure. IPHP participants must report their participation to the applicable physician health program or licensing authority in any state in which the participant is currently licensed or in which the participant seeks licensure.

14.9(2) The IPHC is authorized to communicate information about an IPHP participant to any person assisting in the participant's treatment, recovery, rehabilitation, monitoring, or maintenance.

14.9(3) The IPHC is authorized to communicate information about an IPHP participant to the board in the event a participant does not comply with the terms of the contract. The IPHC may provide the board with a participant's IPHP file in the event the participant does not comply with the terms of the contract and the IPHC refers the case to the board for the filing of formal disciplinary charges or other appropriate action. If the board initiates disciplinary action against a licensee for noncompliance with the terms of the contract, the board may include information about a licensee's participation in the IPHP in the statement of charges, settlement agreement and final order, or order following hearing.

14.9(4) The IPHC is authorized to communicate information about an IPHP participant to the board if reliable information held by the IPHC reasonably indicates a significant risk to the public exists. If the board initiates disciplinary action based upon this information, the board may include information about a licensee's participation in the IPHP in the statement of charges, settlement agreement and final order, or order following hearing if necessary to address impairment issues related to the violations which are the subject of the disciplinary action.

14.9(5) The IPHC shall file with the board a report on board-referred cases upon the licensee's successful completion of the program.

14.9(6) The IPHC shall maintain a participant's complete IPHP file for the ten-year period after a participant's contract has expired or is terminated. After that period, the Executive Summary and contract shall be retained.
[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

653—14.10(28E) Authority for 28E agreements. The IPHC may enter into 28E agreements with other health professional licensing boards to evaluate, assist, and monitor impaired licensees from other health professions who self-report and to report to those professional licensing boards regarding the compliance of individual licensees. In the event of noncompliance, the licensee may be referred to the appropriate

licensing board for appropriate disciplinary action. If the IPHC enters into a 28E agreement with another health professional licensing board, this chapter applies and the word "physician" shall be replaced with the word "licensee" for the purpose of interpreting this chapter.

653—14.11(272C) Board referrals to the Iowa physician health committee.

14.11(1) *Eligibility for board referral to IPHP.* The board may refer to the IPHP a licensee or applicant for whom the following circumstances apply:

a. The applicant or licensee has an impairment as defined in rule 653—14.2(272C).

b. The board determines that the applicant or licensee is an appropriate candidate for participation in the IPHP.

NOTE: A licensee who is the subject of a formal board disciplinary order relating to an impairment must demonstrate a sufficient period of compliance with the disciplinary order before referral to the IPHC.

c. The IPHC determines that the applicant or licensee is an appropriate candidate for participation in the IPHP.

14.11(2) *Referral process.*

a. Determination of whether an applicant or licensee is appropriate for referral to the IPHP is in the sole discretion of the board. Upon the board's approval, a referral shall be made to the IPHP and board staff shall provide relevant information about the applicant or licensee to the IPHC.

b. The IPHC shall make a determination whether the applicant or licensee is an appropriate candidate for participation in the IPHP. Upon this determination, the IPHC shall offer the referred applicant or licensee a health contract which provides a detailed description of the goals of the program, the requirements for successful participation, and the applicant's or licensee's obligations therein. See 653—14.6(272C).

c. If the IPHC finds that the applicant or licensee is not an appropriate candidate for participation in the IPHP or if the applicant or licensee fails to sign the health contract in the time period specified by the IPHC, the IPHC shall notify the board promptly.

d. When the referred applicant or licensee signs the contract, the IPHC shall notify the board that the applicant or licensee is an appropriate candidate for participation in the IPHP and that the referral has been finalized.

e. Upon notification that the referral has been finalized for a licensee who is the subject of a formal board disciplinary order relating to the impairment, the board shall file an order referring the licensee to the IPHP, and that order shall be a public record.

f. The IPHC shall notify the board upon the licensee's successful completion of the program. The board may file an order recognizing the licensee's successful completion of the program in cases where the referral was included in a public record. An order recognizing completion of the program shall be a public record.

g. Referral of an applicant or licensee by the board to the IPHP shall not relieve the board of any duties of the board and shall not divest the board of any authority or jurisdiction otherwise provided. Upon referral, the applicant or licensee shall be subject to the provisions of 653—Chapter 14. Specifically, the applicant or licensee shall be subject to board review and potential formal disciplinary action pursuant to subrule 14.7(2) for noncompliance with the provisions of the IPHP health contract.

14.11(3) *Investigation and disciplinary action on referrals.* Rescinded IAB 6/30/10, effective 8/4/10.

[**ARC 8917B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement Iowa Code section 272C.3 as amended by 2003 Iowa Acts, House File 641, section 6.

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PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of [620], renamed Pharmacy Examiners Board[657] under the "umbrella" of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

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HOSPITAL PHARMACY PRACTICE

[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 12]

657—7.1(155A) Purpose and scope. Hospital pharmacy means and includes a pharmacy licensed by the board and located within any hospital, health system, institution, or establishment which maintains and operates organized facilities for the diagnosis, care, and treatment of human illnesses to which persons may or may not be admitted for overnight stay at the facility. A hospital is a facility licensed pursuant to Iowa Code chapter 135B. This chapter does not apply to a pharmacy located within such a facility for the purpose of providing outpatient prescriptions. A pharmacy providing outpatient prescriptions is and shall be licensed as a general pharmacy subject to the requirements of 657—Chapter 6. The requirements of these rules for hospital pharmacy practice apply to all hospitals, regardless of size or type, and are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to services provided by the pharmacy.

657—7.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the items identified in this rule. A part-time pharmacist in charge has the same obligations and responsibilities as a full-time pharmacist in charge. Where 24-hour operation of the pharmacy is not feasible, a pharmacist shall be available on an "on call" basis. The pharmacist in charge, at a minimum, shall be responsible for:

1. Ensuring that the pharmacy utilizes an ongoing, systematic program for achieving performance improvement and ensuring the quality of pharmaceutical services.
2. Ensuring that the pharmacy employs an adequate number of qualified personnel commensurate with the size and scope of services provided by the pharmacy and sufficient to ensure adequate levels of quality patient care services. Drug dispensing by nonpharmacists shall be minimized and eliminated wherever possible.
3. Ensuring the availability of any equipment and references necessary for the particular practice of pharmacy.
4. Ensuring that a pharmacist performs therapeutic drug monitoring and drug use evaluation.
5. Ensuring that a pharmacist provides drug information to other health professionals and to patients.
6. Dispensing drugs to patients, including the packaging, preparation, compounding, and labeling functions performed by pharmacy personnel.
7. Delivering drugs to the patient or the patient's agent.
8. Ensuring that patient medication records are maintained as specified in rule 657—7.10(124,155A).
9. Training pharmacy technicians and pharmacy support persons.
10. Ensuring adequate and appropriate pharmacist oversight and supervision of pharmacy technicians and pharmacy support persons.
11. Procuring and storing prescription drugs and devices and other products dispensed from the pharmacy.
12. Distributing and disposing of drugs from the pharmacy.
13. Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations.
14. Establishing and maintaining effective controls against the theft or diversion of prescription drugs, controlled substances, and records for such drugs.
15. Preparing a written operations manual governing pharmacy functions; periodically reviewing and revising those policies and procedures to reflect changes in processes, organization, and other pharmacy functions; and ensuring that all pharmacy personnel are familiar with the contents of the manual.

16. Ensuring the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy.
[**ARC 8673B**, IAB 4/7/10, effective 6/1/10]

657—7.3(155A) Reference library. References may be printed or computer-accessed. A reference library shall be maintained which includes, as a minimum, one current reference from each of the following categories, including access to current periodic updates.

1. The Iowa Pharmacy Law and Information Manual.
2. A patient information reference that includes or provides patient information in compliance with rule 657—6.14(155A).
3. A reference on drug interactions.
4. A general information reference.
5. A drug equivalency reference.
6. An injectable-drug compatibility reference.
7. A drug identification reference to enable identification of drugs brought into the facility by patients.
8. The readily accessible telephone number of a poison control center that serves the area.
9. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served. For example, the treatment of pediatric patients and oncology patients would require additional references unique to those specialties.

657—7.4 and **7.5** Reserved.

657—7.6(124,155A) Security. The pharmacy shall be located in an area or areas that facilitate the provision of services to patients and shall be integrated with the facility's communication and transportation systems. The following conditions must be met to ensure appropriate control over drugs and chemicals in the pharmacy:

7.6(1) *Pharmacist responsibility.* Each pharmacist, while on duty, shall be responsible for the security of the pharmacy area, including provisions for effective control against theft of, diversion of, or unauthorized access to drugs or devices, controlled substances, records for such drugs, and patient records as provided in 657—Chapter 21. Policies and procedures shall identify the minimum amount of time that a pharmacist is available at the hospital pharmacy.

7.6(2) *Access when pharmacist absent.* When the pharmacist is absent from the facility, the pharmacy is closed. Policies and procedures shall be established that identify who will have access to the pharmacy when the pharmacy is closed and the procedures to be followed for obtaining drugs, devices, and chemicals to fill an emergent need during the pharmacist's absence.

a. The pharmacist in charge may designate pharmacy technicians or pharmacy support persons who may be present in the pharmacy to perform technical or nontechnical functions, respectively, designated by the pharmacist in charge. Activities identified in paragraph *"d"* of this subrule may not be performed when the pharmacy is closed.

b. If the pharmacist in charge has authorized the presence in the pharmacy of a pharmacy technician or a pharmacy support person to perform designated functions when the pharmacy is closed, only a pharmacy technician may assist another authorized, licensed health care professional to locate a drug or device pursuant to an emergent need. The pharmacy technician or the pharmacy support person may not dispense or deliver the drug, chemical, or device to the licensed health care professional. The licensed health care professional shall comply with established policies and procedures for obtaining drugs, devices, and chemicals when the pharmacy is closed. The licensed health care professional shall not ask or expect the pharmacy technician or the pharmacy support person to verify that the appropriate drug, chemical, or device has been obtained from the pharmacy.

c. A pharmacy technician or a pharmacy support person who is present in the pharmacy when the pharmacy is closed shall prepare and maintain in the pharmacy a log identifying each period of time that the pharmacy technician or pharmacy support person worked in the pharmacy while the pharmacy was

closed and identifying each activity performed during that time period. Each entry shall be dated and each daily record shall be signed by the pharmacy technician or pharmacy support person who prepared the record. The log shall be periodically reviewed by the pharmacist in charge.

d. Activities which shall not be performed by a pharmacy technician or a pharmacy support person when the pharmacist is absent from the facility include:

(1) Dispensing, delivering, or distributing any prescription drugs or devices to patients or others, including health care professionals, prior to pharmacist verification. Verification by a nurse or other licensed health care professional shall not supplant verification by a pharmacist.

(2) Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.

(3) Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.21(155A).

(4) Providing patient counseling, consultation, or drug information.

(5) Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.

(6) Preparing compounded drug products for immediate administration by other hospital staff or health care professionals without verification by a pharmacist.

7.6(3) *Locked areas.* All pharmacy areas where drugs or devices are maintained or stored and where a pharmacist is not continually present shall be locked.

7.6(4) *Verification by pharmacist.* When the pharmacy is open, patient-specific drugs or devices shall not be distributed prior to the pharmacist's final verification and approval.

7.6(5) *Drugs or devices in patient care areas.* Drugs or devices maintained or stored in patient care areas shall be in locked storage unless the patient care unit is staffed by health care personnel and the medication area is visible to staff at all times.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10]

657—7.7(155A) Verification by pharmacist when pharmacy is closed. A hospital pharmacy may contract with another pharmacy for remote pharmacist preview and verification of patient-specific drugs or devices ordered for a patient when the hospital pharmacy is closed. Contracted services may include pharmacist order entry pursuant to subrule 7.8(3). Pharmacies entering into a contract or agreement pursuant to this rule shall comply with the following requirements:

7.7(1) *Nonsupplanting service.* A contract or agreement for remote pharmacist services shall not relieve the hospital pharmacy from employing or contracting with a pharmacist to provide routine pharmacy services within the facility. The activities authorized by this rule are intended to supplement hospital pharmacy services when the pharmacy is closed and are not intended to eliminate the need for an on-site hospital pharmacy or pharmacist.

7.7(2) *Hospital-staff pharmacist.* Nothing in this rule shall prohibit a pharmacist employed by or contracting with a hospital pharmacy for on-site services from also providing remote preview and verification of patient-specific drugs or devices ordered for a patient when the hospital pharmacy is closed. A pharmacist previewing and verifying drug or device orders from a remote location shall have access to patient information pursuant to subrule 7.7(4) or 7.7(5), shall have access to the prescriber as provided in subrule 7.7(6), and shall be identified on the drug or device order as provided in subrule 7.7(7).

7.7(3) *Licenses required.* A pharmacy contracting with a hospital pharmacy to provide services pursuant to this rule shall maintain with the board a current Iowa pharmacy license. A remote pharmacist providing pharmacy services as an employee or agent of a contracting pharmacy pursuant to this rule shall be licensed to practice pharmacy in Iowa.

7.7(4) *Electronic access to patient information.* The remote pharmacist shall have secure electronic access to the hospital pharmacy's patient information system and to all other electronic systems that the on-site pharmacist has access to when the pharmacy is open. The remote pharmacist shall receive training in the use of the hospital's electronic systems.

7.7(5) *Nonelectronic patient information.* If a hospital's patient information is not maintained in an electronic data system or if the hospital pharmacy is not able to provide remote electronic access to the patient information system, the hospital pharmacy may petition for a waiver of subrule 7.7(4) pursuant to 657—Chapter 34 and this subrule. In addition to the information required pursuant to 657—Chapter 34, the petition for waiver shall identify the hospital pharmacy's alternative to the electronic sharing of patient information, shall explain in detail how the alternative method will ensure timely provision of patient information necessary for the remote pharmacist to effectively review the patient's drug regimen and history, and shall detail the processes involved in the alternative proposal including identification of all individuals involved in each of those processes.

7.7(6) *Access to prescriber.* The remote pharmacist shall be able to contact the prescriber to discuss any concerns identified during the pharmacist's review of the patient's information.

7.7(7) *Pharmacist identified.* The record of each patient-specific drug or device order processed pursuant to this rule shall identify, by name or other unique identifier, each pharmacist involved in the preview and verification of the order.

657—7.8(124,126,155A) Drug distribution and control. Policies and procedures governing drug distribution and control shall be developed by the pharmacist in charge with input from other involved hospital staff such as physicians and nurses, from committees such as the pharmacy and therapeutics committee or its equivalent, and from any related patient care committee. It is essential that the pharmacist in charge or designee routinely be available to or on all patient care areas to establish rapport with the personnel and to become familiar with and contribute to medical and nursing procedures relating to drugs.

7.8(1) *Drug preparation.* The pharmacist shall institute the control procedures needed to ensure that patients receive the correct drugs at the proper times. Adequate quality assurance procedures shall be developed.

a. Hospitals shall utilize a unit dose dispensing system pursuant to rule 657—22.1(155A). All drugs dispensed by the pharmacist for administration to patients shall be in single unit or unit dose packages if practicable unless the dosage form or drug delivery device makes it impracticable to package the drug in a unit dose or single unit package.

(1) The pharmacist in charge shall establish policies and procedures that identify situations when drugs may be dispensed in other than unit dose or single unit packages outside the unit dose dispensing system.

(2) The need for nurses to manipulate drugs prior to their administration shall be minimized.

b. Pharmacy personnel shall, except as specified in policies and procedures, prepare all sterile products in conformance with 657—Chapter 13.

c. Pharmacy personnel shall compound or prepare drug formulations, strengths, dosage forms, and packages useful in the care of patients.

7.8(2) *Drug formulary.* The pharmacist in charge shall maintain a current formulary of drug products approved for use in the institution and shall be responsible for specifications for those drug products and for selecting their source of supply.

7.8(3) *Medication orders.* Except as provided in subrule 7.8(14), a pharmacist shall receive a copy of the original medication order for review except when the prescriber directly enters the medication order into an electronic medical record system or when the prescriber issues a verbal medication order directly to a registered nurse or pharmacist who then enters the order into an electronic medical record system. If an individual other than the prescriber enters a medication order into an electronic medical record system, the pharmacist shall review and verify the entry against the original order before the drug is dispensed except for emergency use, when the pharmacy is closed, or when the original order is a verbal order from the prescriber to the registered nurse or pharmacist, or as provided in rule 657—7.7(155A). When the pharmacy is closed, a registered nurse or pharmacist may enter a medication order into an electronic medical record system for the purpose of creating an electronic medication administration record and a pharmacist shall verify the entry against the original medication order as soon as practicable. Hospitalwide and pharmacy stand-alone computer systems shall be secure

against unauthorized entry. The use of abbreviations and chemical symbols on medication orders shall be discouraged but, if used, shall be limited to abbreviations and chemical symbols approved by the appropriate patient care committee.

7.8(4) *Stop order.* A written policy or other system concerning stop orders shall be established to ensure that medication orders are not inappropriately continued.

7.8(5) *Emergency drug supplies and floor stock.* Supplies of drugs for use in medical emergencies shall be immediately available at each nursing unit or service area as specified in policies and procedures. Authorized stocks shall be periodically reviewed in a multidisciplinary manner. All drug storage areas within the hospital shall be routinely inspected to ensure that no outdated or unusable items are present and that all stock items are properly labeled and stored.

7.8(6) *Disaster services.* The pharmacy shall be prepared to provide drugs and pharmaceutical services in the event of a disaster affecting the availability of drugs or internal access to drugs or access to the pharmacy.

7.8(7) *Drugs brought into the institution.* The pharmacist in charge shall determine those circumstances when patient-owned drugs brought into the institution may be administered to a hospital patient and shall establish policies and procedures governing the use and security of drugs brought into the institution. Procedures shall address identification of the drug and methods for ensuring the integrity of the product prior to permitting its use by the patient. The use of patient-owned drugs shall be minimized to the greatest extent possible.

7.8(8) *Samples.* The use of drug samples within the institution shall be eliminated to the extent possible. Sample use is prohibited for hospital inpatient use. If the use of drug samples is permitted for hospital outpatients, that use of samples shall be controlled and the samples shall be distributed through the pharmacy or through a process developed in cooperation with the pharmacy and the institution's appropriate patient care committee, subject to oversight by the pharmacy.

7.8(9) *Investigational drugs.* If investigational drugs are used in the institution:

a. A pharmacist shall be a member of the institutional review board.

b. The pharmacy shall be responsible, in cooperation with the principal investigator, for providing information about investigational drugs used in the institution and for the distribution and control of those drugs.

7.8(10) *Hazardous drugs and chemicals.* The pharmacist, in cooperation with other hospital staff, shall establish policies and procedures for handling drugs and chemicals that are known occupational hazards. The procedures shall maintain the integrity of the drug or chemical and protect hospital personnel.

7.8(11) *Leave meds.* Labeling of prescription drugs for a patient on leave from the facility for a period in excess of 24 hours shall comply with 657—subrule 6.10(1). The dispensing pharmacy shall be responsible for packaging and labeling leave meds in compliance with this subrule.

7.8(12) *Discharge meds.* Drugs authorized for a patient being discharged from the facility shall be labeled in compliance with 657—subrule 6.10(1) before the patient removes those drugs from the facility premises. The dispensing pharmacy shall be responsible for packaging and labeling discharge meds in compliance with this subrule.

7.8(13) *Own-use outpatient prescriptions.* If the hospital pharmacy dispenses own-use outpatient prescriptions, the pharmacy shall comply with all requirements of 657—Chapter 6 except rule 657—6.1(155A).

7.8(14) *Influenza and pneumococcal vaccines.* As authorized by federal law, a written or verbal patient-specific medication administration order shall not be required prior to administration to an adult patient of influenza and pneumococcal polysaccharide vaccines pursuant to physician-approved hospital policy and after the patient has been assessed for contraindications. Administration shall be recorded in the patient's medical record.

[**ARC 8170B**, IAB 9/23/09, effective 10/28/09]

657—7.9(124,155A) Drug information. The pharmacy is responsible for providing the institution's staff and patients with accurate, comprehensive information about drugs and their use and shall serve as its center for drug information.

7.9(1) *Staff education.* The pharmacist shall keep the institution's staff well informed about the drugs used in the institution and their various dosage forms and packagings.

7.9(2) *Patient education.* The pharmacist shall help ensure that all patients are given adequate information about the drugs that they receive. This is particularly important for ambulatory, home care, and discharged patients. These patient education activities shall be coordinated with the nursing and medical staffs and patient education department, if any.

657—7.10(124,155A) Ensuring rational drug therapy. An important aspect of pharmaceutical services is that of maximizing rational drug use. The pharmacist, in concert with the medical staff, shall develop policies and procedures for ensuring the quality of drug therapy.

7.10(1) *Patient profile.* Sufficient patient information shall be collected, maintained, and reviewed by the pharmacist to ensure meaningful and effective participation in patient care. This requires that a drug profile be maintained for each patient receiving care at the hospital. A pharmacist-conducted drug history from patients may be useful in this regard.

a. Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in daily practice.

b. The pharmacist shall review each patient's current drug regimen and directly communicate any suggested changes to the prescriber.

7.10(2) *Adverse drug events.* The pharmacist, in cooperation with the appropriate patient care committee, shall develop a mechanism for the reporting and review, by the committee or other appropriate medical group, of adverse drug events. The pharmacist shall be informed of all reported adverse drug events occurring in the facility. Adverse drug events include but need not be limited to adverse drug reactions and medication errors.

657—7.11(124,126,155A) Outpatient services. No prescription drugs shall be dispensed to patients in a hospital outpatient setting. If a need is established for the dispensing of a prescription drug to an outpatient, a prescription drug order shall be provided to the patient to be filled at a pharmacy of the patient's choice.

7.11(1) *Definitions.* For the purposes of this rule, the following definitions shall apply:

"Emergency department patient" means an individual who is examined and evaluated in the emergency department.

"Outpatient" means an individual examined and evaluated by a prescriber who determined the individual's need for the administration of a drug or device, which individual presents to the hospital outpatient setting with a prescription or order for administration of a drug or device. "Outpatient" does not include an emergency department patient.

"Outpatient medication order" means a written order from a prescriber or an oral or electronic order from a prescriber or the prescriber's authorized agent for administration of a drug or device. An outpatient medication order may authorize continued or periodic administration of a drug or device for a period of time and frequency determined by the prescriber or by hospital policy, not to exceed legal limits for the refilling of a prescription drug order.

7.11(2) *Administration in the outpatient setting.* Drugs shall be administered only to outpatients who have been examined and evaluated by a prescriber who determined the patient's need for the drug therapy ordered.

a. *Accountability.* A system of drug control and accountability shall be developed and supervised by the pharmacist in charge and the facility's outpatient services committee, or a similar group or person responsible for policy in the outpatient setting. The system shall ensure accountability of drugs incidental to outpatient nonemergency therapy or treatment. Drugs shall be administered only in accordance with the system.

b. *Controlled substances.* Controlled substances maintained in the outpatient setting are kept for use by or at the direction of prescribers for the nonemergency therapy or treatment of outpatients. In order to receive a controlled substance, a patient shall be examined in the outpatient setting or in an alternate practice setting or office by a prescriber who shall determine the patient's need for the drug. If the patient is examined in a setting outside the outpatient setting, the prescriber shall provide the patient with a written prescription or order to be presented at the hospital outpatient setting.

c. *Outpatient medication orders.* A prescriber may authorize, by outpatient medication order, the periodic administration of a drug to an outpatient.

(1) Schedule II controlled substance. An outpatient medication order for administration of a Schedule II controlled substance shall be written and, except as provided in rule 657—10.25(124) regarding the issuance of multiple Schedule II prescriptions, shall authorize a single administration of the prescribed substance.

(2) Schedule III, IV, or V controlled substance. An outpatient medication order for administration of a Schedule III, IV, or V controlled substance shall be written and may be authorized for a period not to exceed six months from the date ordered.

(3) Noncontrolled substance. An outpatient medication order for administration of a noncontrolled prescription drug may be authorized for a period not to exceed 18 months from the date ordered.

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657—7.12(124,126,155A) Drugs in the emergency department. Drugs maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department. Drugs shall be administered or dispensed only to emergency department patients. For the purposes of this rule, "emergency department patient" means an individual who is examined and evaluated in the emergency department.

7.12(1) *Accountability.* A system of drug control and accountability shall be developed and supervised by the pharmacist in charge and the facility's emergency department committee, or a similar group or person responsible for policy in the emergency department. The system shall identify drugs of the nature and type to meet the immediate needs of emergency department patients. Drugs shall be administered or dispensed only in accordance with the system.

7.12(2) *Controlled substances.* Controlled substances maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department.

a. In order to receive a controlled substance, a patient shall be examined in the emergency department by a prescriber who shall determine the need for the drug. It is not permissible under state and federal regulations for a prescriber to see a patient outside the emergency department setting, or talk to the patient on the telephone, and then proceed to call the emergency department and order the administration of a stocked controlled substance upon the patient's arrival at the emergency department except as provided in paragraph 7.12(2)*"c"* or *"d."*

b. A prescriber may authorize, without again examining the patient, the administration of additional doses of a previously authorized drug to a patient presenting to the emergency department within 24 hours of the patient's examination and treatment in the emergency department.

c. In an emergency situation when a health care practitioner authorized to prescribe controlled substances is not available on site, and regardless of the provisions of paragraph 7.12(2)*"a,"* the emergency department nurse may examine the patient in the emergency department and contact the on-call prescriber. The on-call prescriber may then authorize the nurse to administer a controlled substance to the patient pending the arrival of the prescriber at the emergency department. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

d. In an emergency situation when a health care practitioner authorized to prescribe controlled substances examines a patient in the prescriber's office and determines a need for the administration of a controlled substance, and regardless of the provisions of paragraph 7.12(2)*"a,"* the prescriber may direct the patient to present to the emergency department, with a valid written prescription or order for

the administration of the controlled substance. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

7.12(3) *Drug dispensing.* In those facilities with 24-hour pharmacy services, only a pharmacist or prescriber may dispense any drugs to an emergency department patient. In those facilities located in an area of the state where 24-hour outpatient or 24-hour on-call pharmacy services are not available within 15 miles of the hospital, and which facilities are without 24-hour outpatient pharmacy services, the provisions of this rule shall apply.

a. *Pharmacist in charge responsibility.* The pharmacist in charge is responsible for maintaining accurate records of dispensing of drugs from the emergency department and for ensuring the accuracy of prepackaged drugs and the complete and accurate labeling of prepackaged drugs pursuant to this paragraph.

(1) Prepackaging. Except as provided in subrule 7.12(4), drugs dispensed to an emergency department patient in greater than a 24-hour supply may be dispensed only in prepackaged quantities not to exceed a 72-hour supply or the minimum prepackaged quantity in suitable containers, except that a seven-day supply of doxycycline provided through the department of public health pursuant to the crime victim compensation program of the Iowa department of justice may be dispensed for the treatment of a victim of sexual assault. Prepackaged drugs shall be prepared pursuant to the requirements of rule 657—22.3(126).

(2) Labeling. Drugs dispensed pursuant to this paragraph shall be appropriately labeled as required in paragraph 7.12(3)*"b,"* including necessary auxiliary labels.

b. *Prescriber responsibility.* Except as provided in subrule 7.12(4), a prescriber who authorizes dispensing of a prescription drug to an emergency department patient is responsible for the accuracy of the dispensed drug and for the accurate completion of label information pursuant to this paragraph.

(1) Labeling. Except as provided in subrule 7.12(4), at the time of delivery of the drug the prescriber shall appropriately complete the label such that the dispensing container bears a label with at least the following information:

1. Name and address of the hospital;
2. Date dispensed;
3. Name of prescriber;
4. Name of patient;
5. Directions for use;
6. Name and strength of drug.

(2) Delivery of drug to patient. Except as provided in subrule 7.12(4), the prescriber, or a licensed nurse under the supervision of the prescriber, shall give the appropriately labeled, prepackaged drug to the patient or patient's caregiver. The prescriber, or a licensed nurse under the supervision of the prescriber, shall explain the correct use of the drug and shall explain to the patient that the dispensing is for an emergency or starter supply of the drug. If additional quantities of the drug are required to complete the needed course of treatment, the prescriber shall provide the patient with a prescription for the additional quantities.

7.12(4) *Use of InstyMeds dispensing system.* A hospital located in an area of the state where 24-hour outpatient pharmacy services are not available within 15 miles of the hospital may implement the InstyMeds dispensing system in the hospital emergency department only as provided by this subrule.

a. Persons with access to the dispensing machine for the purposes of stocking, inventory, and monitoring shall be limited to pharmacists, pharmacy technicians, and pharmacist-interns.

b. The InstyMeds dispensing system shall be used only in the hospital emergency department for the benefit of patients examined or treated in the emergency department.

c. The dispensing machine shall be located in a secure and professionally appropriate environment.

d. The stock of drugs maintained and dispensed utilizing the InstyMeds dispensing system shall be limited to acute care drugs provided in appropriate quantities for a 72-hour supply or the minimum commercially available package size, except that antimicrobials may be dispensed in a quantity to provide the full course of therapy.

e. Drugs dispensed utilizing the InstyMeds dispensing system shall be appropriately labeled as provided in 657—subrule 6.10(1), paragraphs *"a"* through *"g."*

f. Prior to authorizing the dispensing of a drug utilizing the InstyMeds dispensing system, the prescriber shall offer the patient the option of being provided a prescription that may be filled at the pharmacy of the patient's choice.

g. When appropriate for an acute condition, the prescriber shall provide to the patient or the patient's caregiver a prescription for the remainder of drug therapy beyond the supply available utilizing the InstyMeds dispensing system. During consultation with the patient or the patient's caregiver, the prescriber shall clearly explain the appropriate use of the drug supplied, the need to have a prescription for any additional supply of the drug filled at a pharmacy of the patient's choice, and the need to complete the full course of drug therapy.

h. The pharmacy shall, in conjunction with the hospital emergency department, implement policies and procedures to ensure that a patient utilizing the InstyMeds dispensing system has been positively identified.

i. The hospital pharmacist shall review the printout of drugs provided utilizing the InstyMeds dispensing system within 24 hours unless the pharmacy is closed, in which case the printout shall be reviewed during the first day the pharmacy is open following the provision of the drugs. The purpose of the review is to identify any dispensing errors, to determine dosage appropriateness, and to complete a retrospective drug use review of any antimicrobials dispensed in a quantity greater than a 72-hour supply. Any discrepancies found shall be addressed by the pharmacy's continuous quality improvement program.

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657—7.13(124,155A) Records. Every inventory or other record required to be kept under this chapter or other board rules or under Iowa Code chapters 124 and 155A shall be kept by the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular inventory or record.

7.13(1) *Medication order information.* Each original medication order contained in inpatient records shall bear the following information:

a. Patient name and identification number;

b. Drug name, strength, and dosage form;

c. Directions for use;

d. Date ordered;

e. Practitioner's signature or electronic signature or that of the practitioner's authorized agent.

7.13(2) *Medication order maintained.* The original medication order shall be maintained with the medication administration record in the medical records of the patient following discharge.

7.13(3) *Documentation of drug administration.* Each dose of medication administered shall be properly recorded in the patient's medical record.

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 126.10, 126.11, 155A.6, 155A.13, 155A.27, 155A.28, 155A.31, and 155A.33 through 155A.36.

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◊ Two or more ARCs

CHAPTER 10
CONTROLLED SUBSTANCES

[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

657—10.1(124) Who shall register. Any person or business located in Iowa that manufactures, distributes, dispenses, prescribes, imports or exports, conducts research or instructional activities, or conducts chemical analysis with controlled substances in the state of Iowa, or that proposes to engage in such activities with controlled substances in the state, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 657—10.6(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business.

Manufacturers, distributors, reverse distributors, importers and exporters, individual practitioners (M.D., D.O., D.D.S., D.V.M., D.P.M., O.D., P.A., resident physician, advanced registered nurse practitioner), pharmacies, hospitals and animal shelters, care facilities, researchers and dog trainers, analytical laboratories, and teaching institutions shall register on forms provided by the board office. To be eligible to register, individual practitioners must hold a current, active license in good standing, issued by the appropriate Iowa professional licensing board, to practice their profession in Iowa.

657—10.2(124) Application forms. Application forms may be obtained from the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Forms are also available on the board's Web site, www.state.ia.us/ibpe. Registration renewal forms will be mailed to each registrant approximately 60 days before the expiration date of the registration. A registrant who has not received a renewal form 45 days before the expiration date of the registration is responsible for contacting the board to request an application.

10.2(1) *Signature requirements.* Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:

a. If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.

b. If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location.

10.2(2) *Submission of multiple applications.* Any person or business required to obtain more than one registration may submit all applications in one package. Each application shall be complete and shall not refer to any accompanying application or any attachment to an accompanying application for required information.

657—10.3(124) Registration and renewal. For each registration or timely renewal of a registration to manufacture, distribute, dispense, prescribe, import or export, conduct research or instructional activities, or conduct chemical analysis with controlled substances listed in Schedules I through V of Iowa Code chapter 124, registrants shall pay a biennial fee of $100.

10.3(1) *Time and method of payment.* Registration and renewal fees shall be paid at the time the application for registration or renewal is submitted. Payment should be made in the form of a personal, certified, or cashier's check or a money order made payable to the Iowa Board of Pharmacy. Payments made in the form of foreign currency or third-party endorsed checks will not be accepted.

10.3(2) *Late renewal.* Any registered person or business may apply, on forms provided by the board office, for registration renewal not more than 60 days prior to the expiration of the registration. Failure to renew a registration prior to the first day of the month following expiration shall require payment of the renewal fee and a penalty fee of $100. Payment shall be made as specified in subrule 10.3(1).

657—10.4(124) Exemptions—registration fee. The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care

or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties.

10.4(1) *Law enforcement officials.* In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis. Such laboratories shall be exempt from payment of a fee for registration.

10.4(2) *Registration and duties not exempt.* Exemption from payment of a registration or registration renewal fee as provided in this rule does not relieve the agency or institution of registration or of any other requirements or duties prescribed by law.

657—10.5(124) Separate registration for independent activities; coincident activities. The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

10.5(1) *Manufacturing controlled substances.* A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

10.5(2) *Distributing controlled substances.* This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

10.5(3) *Dispensing or instructing with controlled substances.* This independent activity includes, but is not limited to, prescribing by individual practitioners, dispensing by pharmacies and hospitals, and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for this independent activity may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law.

10.5(4) *Conducting research with controlled substances listed in Schedule I.* A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal Drug Enforcement Administration (DEA) registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

10.5(5) *Conducting research with controlled substances listed in Schedules II through V.* A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3), and may conduct instructional activities with controlled substances.

10.5(6) *Conducting chemical analysis with controlled substances.* A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.

10.5(7) *Importing or exporting controlled substances.* A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.

657—10.6(124) Separate registrations for separate locations; exemption from registration. A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, or dispensed unless the person or business is exempt from registration pursuant to Iowa Code subsection 124.302(3) or this rule.

10.6(1) *Warehouse.* A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

a. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

b. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code subsection 124.302(3).

10.6(2) *Sales office.* An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

10.6(3) *Prescriber's office.* An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber's practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

10.6(4) *Prescriber in hospital.* A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber's registered practice location shall not be required to obtain a separate registration for the hospital.

10.6(5) *Affiliated interns, residents, or foreign physicians.* An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the registrant is employed provided that:

a. The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board;

b. Such individual practitioner is acting only in the scope of employment in the hospital or institution;

c. The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution's DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12); and

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.

657—10.7 to **10.9** Reserved.

657—10.10(124,147,155A) Inspection. The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

657—10.11(124) Modification or termination of registration. A registered individual or business may apply to modify a current registration as provided by this rule.

10.11(1) *Change of substances authorized.* Any registrant may apply to modify the substances authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, registration number, and the substances or schedules to be added to or removed from the registration and shall be signed by the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

10.11(2) *Change of address of registered location.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the address of the registered location by submitting a written request to the board. The request shall include the registrant's name, current address, new address, telephone number, effective date of the address change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the address of the registered location by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(3) *Change of registrant's name.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the registrant's name by submitting a written request to the board. The request shall include the registrant's current name, the new name, address, telephone number, effective date of the name change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification. Change of name, as used in this paragraph, refers to a change of the legal name of the registrant and does not authorize the transfer of a registration issued to an individual practitioner or researcher to another individual practitioner or researcher.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the registrant name by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(4) *Change of ownership of registered business entity.* A change of immediate ownership of a pharmacy, hospital, care facility, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter shall require the completion of an application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(5) *Change of responsible individual.* Any registrant, except an individual practitioner, a researcher, a hospital, or a pharmacy, may apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, the name and title of the current responsible individual and of the new responsible individual, the effective date of the change, and the registration number, and shall be signed by the new responsible individual. No fee shall be required for the modification.

a. Individual practitioners and researchers. Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed.

b. Pharmacies and hospitals. The responsible pharmacist may execute a power of attorney for DEA order forms to change responsibility under the registration issued to the pharmacy or hospital. The power of attorney shall include the name, address, DEA registration number, and Iowa uniform controlled substances Act (CSA) registration number of the registrant. The power of attorney shall

identify the current and new responsible individuals and shall authorize the new responsible individual to execute applications and official DEA order forms to requisition Schedule II controlled substances. The power of attorney shall be signed by both individuals, shall be witnessed by two adults, and shall be maintained by the registrant and available for inspection or copying by representatives of the board or other state or federal authorities.

10.11(6) *Termination of registration.* A registration issued to an individual shall terminate upon the death of the individual. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice.

657—10.12(124) Denial, modification, suspension, or revocation of registration.

10.12(1) *Grounds for suspension or revocation.* The board may suspend or revoke any registration upon a finding that the registrant:

a. Has furnished false or fraudulent material information in any application filed under this chapter;

b. Has had the registrant's federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked;

c. Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant's appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even though entry of the judgment or sentence has been withheld and the individual has been placed on probation;

d. Has committed such acts as would render the registrant's registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section; or

e. Has been subject to discipline by the registrant's respective professional licensing board and the discipline revokes, suspends, or modifies the registrant's authority regarding controlled substances (including, but not limited to, limiting or prohibiting the registrant from prescribing or handling controlled substances). A certified copy of the record of licensee discipline or a copy of the licensee's surrender of the professional license shall be conclusive evidence.

10.12(2) *Limited suspension or revocation.* If the board finds grounds to suspend or revoke a registration, the board may limit revocation or suspension of the registration to the particular controlled substance with respect to which the grounds for revocation or suspension exist. If the revocation or suspension is limited to a particular controlled substance or substances, the registrant shall be given a new certificate of registration for all substances not affected by revocation or suspension; no fee shall be required for the new certificate of registration. The registrant shall deliver the old certificate of registration to the board.

10.12(3) *Denial of registration or registration renewal.* If upon examination of an application for registration or registration renewal, including any other information the board has or receives regarding the applicant, the board determines that the issuance of the registration would be inconsistent with the public interest, the board shall serve upon the applicant an order to show cause why the registration should not be denied.

10.12(4) *Considerations in denial of registration.* In determining the public interest, the board shall consider all of the following factors:

a. Maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels.

b. Compliance with applicable state and local law.

c. Any convictions of the applicant under any federal and state laws relating to any controlled substance.

d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion.

e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.

f. Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.

g. Any other factors relevant to and consistent with the public health and safety.

10.12(5) *Order to show cause.* Before denying, modifying, suspending, or revoking a registration, the board shall serve upon the applicant or registrant an order to show cause why the registration should not be denied, modified, revoked, or suspended. The order to show cause shall contain a statement of the basis therefor and shall call upon the applicant or registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the order. The order to show cause shall also contain a statement of the legal basis for such hearing and for the denial, revocation, or suspension of registration and a summary of the matters of fact and law asserted. If the order to show cause involves the possible denial of registration renewal, the order shall be served not later than 30 days before the expiration of the registration. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension pursuant to subrule 10.12(9).

10.12(6) *Hearing requested.* If an applicant or registrant who has received an order to show cause desires a hearing on the matter, the applicant or registrant shall file a request for a hearing within 30 days after the date of service of the order to show cause. If a hearing is requested, the board shall hold a hearing pursuant to 657—Chapter 35 at the time and place stated in the order and without regard to any criminal prosecution or other proceeding. Unless otherwise ordered by the board, an administrative law judge employed by the department of inspections and appeals shall be assigned to preside over the case and to render a proposed decision for the board's consideration.

10.12(7) *Waiver of hearing.* If an applicant or registrant entitled to a hearing on an order to show cause fails to file a request for hearing, or if the applicant or registrant requests a hearing but fails to appear at the hearing, the applicant or registrant shall be deemed to have waived the opportunity for a hearing unless the applicant or registrant shows good cause for such failure.

10.12(8) *Final board order when hearing waived.* If an applicant or registrant entitled to a hearing waives or is deemed to have waived the opportunity for a hearing, the executive director of the board may cancel the hearing and issue, on behalf of the board, the board's final order on the order to show cause.

10.12(9) *Order of immediate suspension.* The board may suspend any registration simultaneously with the service upon the registrant of an order to show cause why such registration should not be revoked or suspended if it finds there is an imminent danger to the public health or safety that warrants such action. If the board suspends a registration simultaneously with the service of the order to show cause upon the registrant, it shall serve an order of immediate suspension containing a statement of its findings regarding the danger to public health or safety upon the registrant with the order to show cause. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review thereof, under the provisions of the Iowa administrative procedure Act, unless sooner withdrawn by the board or dissolved by the order of the district court or an appellate court.

10.12(10) *Disposition of controlled substances.* If the board suspends or revokes a registration, the registrant shall promptly return the certificate of registration to the board. Also, upon service of the order of the board suspending or revoking the registration, the registrant shall deliver all affected controlled substances in the registrant's possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order's becoming final, all such controlled substances may be forfeited to the state.

10.12(11) *Notifications.* The board shall promptly notify the DEA and the Iowa department of public safety of all orders suspending or revoking registration and all forfeitures of controlled substances.

657—10.13 and **10.14** Reserved.

657—10.15(124,155A) Security requirements. All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a person has provided effective controls against diversion, the board shall use the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

10.15(1) *Physical security.* Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

a. Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet.

b. Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

10.15(2) *Factors in evaluating physical security systems.* In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

a. The type of activity conducted;

b. The type, form, and quantity of controlled substances handled;

c. The location of the premises and the relationship such location bears to security needs;

d. The type of building construction comprising the facility and the general characteristics of the building or buildings;

e. The type of vault, safe, and secure enclosures available;

f. The type of closures on vaults, safes, and secure enclosures;

g. The adequacy of key control systems or combination lock control systems;

h. The adequacy of electric detection and alarm systems, if any;

i. The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas;

j. The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any;

k. The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel;

l. The availability of local police protection or of the registrant's or applicant's security personnel; and

m. The adequacy of the registrant's or applicant's system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

10.15(3) *Manufacturing and compounding storage areas.* Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

657—10.16(124) Report of theft or loss. A registrant shall report in writing, on forms provided by the board, any theft or significant loss of any controlled substance when the loss is attributable to other than inadvertent error. The report shall be submitted to the board office within two weeks of the discovery of the theft or loss. Thefts shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action is taken against them. A copy of the report shall be maintained in the files of the registrant, and the board will provide a copy of the report to the DEA. In addition to this required report, DEA requires the registrant to deliver notice, immediately

upon discovery of a theft or significant loss of controlled substances, to the nearest DEA field office via telephone, facsimile, or a brief written message explaining the circumstances.

657—10.17(124) Accountability of stock supply. An individual who administers a controlled substance from a non-patient-specific, stock supply in an institutional setting shall personally document on a separate readily retrievable record system each dose administered, wasted, or returned to the pharmacy. Such documentation shall not be delegated to another individual. Wastage documentation shall include the signature of a witnessing licensed health care practitioner.

Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

1. Patient's name;
2. Prescriber who ordered drug;
3. Name of drug, dosage form, and strength;
4. Time and date of administration to patient and quantity administered;
5. Signature or unique electronic signature of individual administering controlled substance;
6. Returns to the pharmacy;
7. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

657—10.18(124) Disposal. Any persons legally authorized to possess controlled substances in the course of their professional practice or the conduct of their business shall dispose of such drugs pursuant to the procedures and requirements of this rule. Disposal records shall be maintained in the files of the registrant.

10.18(1) *Registrant stock supply.* Pharmacy personnel, registrants, and registrant staff shall remove from current inventory and dispose of controlled substances by one of the following procedures.

a. The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm.

b. The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

(1) By delivery to an agent of the board or to the board office;

(2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual; or

(3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

10.18(2) *Waste.* Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant's stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the destruction or other disposal. The record shall include the signatures of the individual destroying or otherwise disposing of the waste controlled substance and of the witnessing licensed health care provider or registered pharmacy technician and shall identify the following:

a. The controlled substance wasted;

b. The date of destruction or other disposition;

c. The quantity or estimated quantity of the wasted controlled substance;

d. The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance; and

e. The reason for the waste.

10.18(3) *Previously dispensed controlled substances.* Controlled substances dispensed to or for a patient and subsequently requiring destruction due to discontinuance of the drug, death of the patient, or other reasons necessitating destruction may be destroyed or otherwise disposed of by a pharmacist in

witness of one other responsible adult pursuant to this subrule. All licenses and registrations issued to the pharmacy, the pharmacist, and any individual witnessing the destruction or other disposition shall not be subject to sanctions relating to controlled substances at the time of the destruction or disposition. The individuals involved in the destruction or other disposition shall not have been subject to any criminal, civil, or administrative action relating to violations of controlled substances laws, rules, or regulations within the past five years. The pharmacist in charge shall be responsible for designating pharmacists authorized to participate in the destruction or other disposition pursuant to this subrule. The authorized pharmacist shall prepare and maintain in the pharmacy a readily retrievable record of the destruction or other disposition, which shall be clearly marked to indicate the destruction or other disposition of noninventory or patient drugs. The record shall include, at a minimum, the following:

a. Source of the controlled substance (patient identifier or administering practitioner, if applicable, and date of return);

b. The name, strength, and dosage form of the substance;

c. The quantity returned and destroyed or otherwise disposed;

d. The date the substance is destroyed or otherwise disposed;

e. The signatures or other unique identification of the pharmacist and the witness.

657—10.19 and **10.20** Reserved.

657—10.21(124,126,155A) Prescription requirements. All prescriptions for controlled substances shall be dated as of, and manually signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue.

10.21(1) *Form of prescription.* All prescriptions shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's signature. When an oral order is not permitted, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. A secretary or agent may prepare a prescription for the signature of the prescriber but the prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

10.21(2) *Verification by pharmacist.* The pharmacist shall verify the authenticity of the prescription with the individual prescriber in each case when a prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

10.21(3) *Intern, resident, foreign physician.* An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.6(5) shall include on all prescriptions issued the hospital's registration number and the special internal code number assigned by the hospital in lieu of the prescriber's registration number required by this rule. Each prescription shall include the stamped or printed name of the intern, resident, or foreign physician as well as the prescriber's signature.

10.21(4) *Valid prescriber/patient relationship.* Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient's use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber's authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

10.21(5) *Schedule II prescriptions.* With appropriate verification, a pharmacist may add information provided by the patient or patient's agent, such as the patient's address, to a Schedule II controlled substance prescription. A pharmacist shall never change the patient's name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber. After consultation with the prescribing practitioner and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

a. The drug strength;

b. The dosage form;

c. The drug quantity;

d. The directions for use; and

e. The date the prescription was issued.

657—10.22(124) Schedule II emergency prescriptions.

10.22(1) *Emergency situation defined.* For the purposes of authorizing an oral or electronically transmitted prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term "emergency situation" means those situations in which the prescribing practitioner determines that all of the following apply:

a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.

b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.

c. It is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance prior to the dispensing.

10.22(2) *Requirements of emergency prescription.* In the case of an emergency situation as defined herein, a pharmacist may dispense a controlled substance listed in Schedule II pursuant to an electronic transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner.

b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist's name or unique identification.

c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the electronic transmission or a written record of the oral transmission authorizing the emergency dispensing. If the emergency prescription is transmitted by the practitioner's agent, the record shall include the name and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via electronic transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the electronic transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 657—10.21(124,126,155A), the prescription shall have written on its face "Authorization for Emergency Dispensing" and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph *"c."*

f. The pharmacist shall notify the board if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board, or failure of the prescribing individual

to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.
[**ARC 7636B**, IAB 3/11/09, effective 4/15/09]

657—10.23(124) Schedule II prescriptions—partial filling. The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule.

10.23(1) *Insufficient supply on hand.* If the pharmacist is unable to supply the full quantity called for in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

10.23(2) *Long-term care or terminally ill patient.* A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

a. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

b. The pharmacist shall record on the prescription whether the patient is "terminally ill" or an "LTCF patient." For each partial filling, the dispensing pharmacist shall record on the back of the prescription, or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

c. The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

d. Information pertaining to current Schedule II prescriptions for patients in a LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.4(124,155A).

657—10.24(124) Schedule II medication order. Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.18(124,155A), as applicable.

657—10.25(124) Schedule II—issuing multiple prescriptions. An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance pursuant to the provisions and limitations of this rule.

10.25(1) *Refills prohibited.* The issuance of refills for a Schedule II controlled substance is prohibited. The use of multiple prescriptions for the dispensing of Schedule II controlled substances, pursuant to this rule, ensures that the prescriptions are treated as separate dispensing authorizations and not as refills of an original prescription.

10.25(2) *Legitimate medical purpose.* Each separate prescription issued pursuant to this rule shall be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber's professional practice.

10.25(3) *Dates and instructions.* Each prescription issued pursuant to this rule shall be dated as of and manually signed by the prescriber on the day the prescription is issued. Each separate prescription, other than the first prescription if that prescription is intended to be filled immediately, shall contain written instructions indicating the earliest date on which a pharmacist may fill each prescription.

10.25(4) *Authorized fill date unalterable.* Regardless of the provisions of subrule 10.21(5), when a prescription contains instructions from the prescriber indicating that the prescription shall not be filled before a certain date, a pharmacist shall not fill the prescription before that date. The pharmacist shall not contact the prescriber for verbal authorization to fill the prescription before the fill date originally indicated by the prescriber pursuant to this rule.

10.25(5) *Number of prescriptions and authorized quantity.* An individual prescriber may issue for a patient as many separate prescriptions, to be filled sequentially pursuant to this rule, as the prescriber deems necessary to provide the patient with adequate medical care. The cumulative effect of the filling of each of these separate prescriptions shall result in the receipt by the patient of a quantity of the Schedule II controlled substance not exceeding a 90-day supply.

10.25(6) *Prescriber's discretion.* Nothing in this rule shall be construed as requiring or encouraging an individual prescriber to issue multiple prescriptions pursuant to this rule or to see the prescriber's patients only once every 90 days when prescribing Schedule II controlled substances. An individual prescriber shall determine, based on sound medical judgment and in accordance with established medical standards, how often to see patients and whether it is appropriate to issue multiple prescriptions pursuant to this rule.

[**ARC 8172B**, IAB 9/23/09, effective 10/28/09]

657—10.26 Reserved.

657—10.27(124,155A) Facsimile transmission of a controlled substance prescription.

10.27(1) *Schedule II prescription.* A prescription for a Schedule II controlled substance may be transmitted via facsimile to the pharmacy only as provided in rules 657—21.12(124,155A) to 657—21.16(124,155A).

10.27(2) *Schedule III, IV, or V prescription.* A prescription for a Schedule III, IV, or V controlled substance may be transmitted via facsimile to the pharmacy only as provided in rule 657—21.9(124,155A).

657—10.28(124,155A) Schedule III, IV, or V refills. No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times.

10.28(1) *Record.* Each filling and refilling of a prescription shall be entered on the prescription or on another uniformly maintained and readily retrievable record.

a. The following information shall be retrievable by the prescription number: the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, the unique identification of the dispensing pharmacist for each refill, and the total number of refills authorized for that prescription.

b. If the pharmacist merely initials or affixes the pharmacist's unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

10.28(2) *Oral refill authorization.* The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

a. The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.

b. The pharmacist who obtains the oral authorization records from the prescriber who issued the original prescription records on or with the original prescription the date, the quantity of each refill, the number of additional refills authorized, and the pharmacist's unique identification.

c. The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

d. The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

10.28(3) *Automated data processing record system.* An automated data processing record system may be used for the storage and retrieval of Schedule III, IV, and V controlled substance prescription fill and refill information subject to the conditions and requirements of rules 657—21.4(124,155A) and 657—21.5(124,155A).

657—10.29(124,155A) Schedule III, IV, or V partial fills. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill. The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed. No dispensing shall occur later than six months after the date on which the prescription was issued.

657—10.30(124,155A) Schedule III, IV, and V medication order. A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

657—10.31(124,155A) Dispensing Schedule V controlled substances without a prescription. A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.31(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.31(2) *Frequency and quantity.* Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

a. 240 cc (8 ounces) of any controlled substance containing opium.

b. 120 cc (4 ounces) of any other controlled substance.

c. 48 dosage units of any controlled substance containing opium.

d. 24 dosage units of any other controlled substance.

10.31(3) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.31(4) *Identification.* The pharmacist shall require every purchaser under this rule not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

10.31(5) *Record.* A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

10.31(6) *Prescription not required under other laws.* No other federal or state law or regulation requires a prescription prior to distributing or dispensing a Schedule V controlled substance.

657—10.32(124,155A) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription. A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.32(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has

authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.32(2) *Packaging of nonliquid forms.* A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

10.32(3) *Frequency and quantity.* Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

10.32(4) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.32(5) *Identification.* The pharmacist shall require every purchaser under this rule to present a current government-issued photo identification, including proof of age when appropriate. The pharmacist shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

10.32(6) *Record.* Purchase records shall be recorded in the real-time electronic pseudoephedrine tracking system (PTS) established and administered by the governor's office of drug control policy pursuant to 657—Chapter 100. If the real-time electronic repository is unavailable for use, the purchase record shall be recorded in an alternate format and submitted to the PTS as provided in 657—subrule 100.3(4).

a. *Alternate record contents.* The alternate record shall contain the following:

(1) The name, address, and signature of the purchaser.

(2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.

(3) The date and time of the purchase.

(4) The name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the product.

b. *Alternate record format.* The record shall be maintained using one of the following options:

(1) A hard-copy record.

(2) A record in the pharmacy's electronic prescription dispensing record-keeping system that is capable of producing a hard-copy printout of a record.

(3) A record in an electronic data collection system that captures each of the data elements required by this subrule and that is capable of producing a hard-copy printout of a record.

c. *PTS records retrieval.* Pursuant to 657—subrule 100.4(6), the pharmacy shall be able to produce a hard-copy printout of transactions recorded in the PTS by the pharmacy for one or more specific products for a specified period of time upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

10.32(7) *Notice required.* The pharmacy shall ensure that the following notice is provided to purchasers of ephedrine, pseudoephedrine, or phenylpropanolamine products and that the notice is displayed with or on the electronic signature device or is displayed in the dispensing area and visible to the public:

"WARNING: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than $250,000 if an individual or $500,000 if an organization, imprisoned not more than five years, or both."

[**ARC 8892B**, IAB 6/30/10, effective 9/1/10]

657—10.33(124,155A) Schedule II perpetual inventory in pharmacy. Each pharmacy located in Iowa that dispenses Schedule II controlled substances shall maintain a perpetual inventory system for all Schedule II controlled substances pursuant to the requirements of this rule. All records relating to

the perpetual inventory shall be maintained by the pharmacy and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

10.33(1) *Record format.* The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.

10.33(2) *Information included.* The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each prescription filled and each shipment received. The record shall also include incident reports and reconciliation records pursuant to subrules 10.33(3) and 10.33(4).

10.33(3) *Changes to a record.* If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

10.33(4) *Reconciliation.* The pharmacist in charge shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance on a periodic basis but no less frequently than annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the pharmacist in charge shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 10.16(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or agents of the board for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

a. The dispensing pharmacist verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. All discrepancies shall be reported to the pharmacist in charge. If any Schedule II controlled substances in the pharmacy's current inventory have been dispensed and verified in this manner within the year, and there are no discrepancies noted, no additional reconciliation action is required. A drug that has had no activity within the year shall be reconciled pursuant to paragraph *"b"* of this subrule.

b. A physical count of each Schedule II controlled substance stocked by the pharmacy shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual's initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory. Any discrepancies between the physical inventory and the perpetual inventory shall be reported to the pharmacist in charge.

657—10.34(124,155A) Records. Every inventory or other record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department.

10.34(1) *Schedule I and II records.* Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

10.34(2) *Schedule III, IV, and V records.* Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

10.34(3) *Date of record.* The date on which a controlled substance is actually received, imported, distributed, exported, or otherwise transferred shall be used as the date of receipt or distribution.

10.34(4) *Receipt and disbursement records.* Each record of receipt or disbursement of controlled substances, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

a. The name of the substance;

b. The strength and dosage form of the substance;

c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;

d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and

e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

10.34(5) *Dispensing records.* Each record of dispensing of controlled substances to a patient or research subject shall include the following information:

a. The name and address of the person to whom dispensed;

b. The date of dispensing;

c. The name of the substance;

d. The quantity of the substance dispensed; and

e. The name or unique identification of the individual who dispensed or administered the substance.

10.34(6) *Ordering or distributing Schedule I or II controlled substances - DEA Form 222.* Except as otherwise provided by subrule 10.34(7) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant's DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.

b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.

c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received, and the date of receipt, and shall initial each line identifying a substance received.

d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.

e. Order forms shall be maintained separately from all other records of the registrant.

f. Each unaccepted, defective, or otherwise "void" order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.

g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

10.34(7) *Ordering or distributing Schedule I or II controlled substances - electronic ordering system.* A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

a. For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser's agent by the DEA.

b. An electronic order may include controlled substances that are not in Schedules I and II and may also include noncontrolled substances.

c. A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

d. Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant's authority to order the controlled substances.

e. The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

f. If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

g. When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

h. A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

i. Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board's agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

[**ARC 8539B**, IAB 2/24/10, effective 4/1/10]

657—10.35(124,155A) Physical count and record of inventory. Responsibility for ensuring that a required inventory is timely completed shall rest with the registrant or, in the case of a registered business, shall rest with the owner of the business. A registrant or owner of a registered business may delegate the actual taking of any inventory. The person or persons responsible for taking the inventory shall sign the completed inventory record.

10.35(1) *Record and procedure.* Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.33(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

a. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

b. Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. These shall include prescriptions prepared for dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical services programs or care facility emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

(1) The name of the substance;

(2) The strength and dosage form of the substance; and

(3) The quantity of the substance.

g. For all substances listed in Schedule I or II, and for all solid oral and injectable hydrocodone-containing products, the quantity shall be an exact count or measure of the substance.

h. For all substances listed in Schedule III, IV, or V, except for hydrocodone-containing products identified in paragraph *"g"* herein, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Liquid oral hydrocodone-containing products packaged in incremented containers shall be measured to the nearest increment; products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

10.35(2) *Initial inventory.* A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

10.35(3) *Annual inventory.* After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within one year of the previous inventory date.

10.35(4) *Change of ownership.* Both the current owner and the prospective owner shall be responsible for ensuring that an inventory of all controlled substances is timely completed whenever there is a change of ownership of any pharmacy or drug wholesaler licensed pursuant to Iowa Code section 155A.13 or 155A.17, respectively.

10.35(5) *Change of pharmacist in charge (PIC).* An inventory of all controlled substances shall be completed whenever there is a change of PIC. The inventory shall be taken following the close of business the last day of the terminating PIC's employment and prior to opening for business the first day of the new PIC's employment. A single inventory shall be sufficient if there is no lapse between employment of the terminating PIC and the new PIC.

10.35(6) *Change of registered location.* A registrant shall take an inventory of all controlled substances whenever there is a change of registered location. The inventory shall be taken following the close of business the last day at the location being vacated. This inventory shall serve as the ending inventory for the location being vacated as well as a record of beginning inventory for the new location.

10.35(7) *Discontinuing registered activity.* A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If the registrant is selling or transferring the remaining controlled substances to another registrant, this

inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to whom the substances are transferred.

10.35(8) *Newly controlled substances.* On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances, any registrant who possesses the newly controlled substance shall take an inventory of all stocks of the substance on hand. That initial inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the newly controlled substance shall be included in each inventory made by the registrant.

657—10.36(124) Samples and other complimentary packages—records. Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items leaves with the practitioner a specific written list of the items delivered.

10.36(1) *Distribution record.* The record form for the distribution of complimentary packages of controlled substances shall contain the following information:

a. The name, address, and DEA registration number of the supplier;

b. The name, address, and DEA registration number of the practitioner;

c. The name, strength, and quantity of the specific controlled substances delivered; and

d. The date of delivery.

10.36(2) *Reports to the board.* Any person who distributes controlled substances pursuant to this rule shall report all such distributions to the board. Reports shall:

a. Include the information identified in subrule 10.36(1). Reports may consist of copies of those distribution records or may be computer-generated listings identifying those distributions.

b. Be submitted as soon as practicable after distribution to the practitioner but no less often than once each calendar quarter.

10.36(3) *Practitioner records.* A practitioner who regularly administers or dispenses controlled substances shall keep records of the receipt and disbursement of such drugs, including complimentary packages and samples. Records shall be filed in a readily retrievable manner in accordance with federal requirements and shall be made available for inspection and copying by agents of the board or other authorized individuals for at least two years from the date of the record.

657—10.37(124,126) Revision of controlled substances schedules.

10.37(1) *Application for exception.* Any person seeking to have any compound, mixture, or preparation containing any depressant or stimulant substance listed in any of the schedules in Iowa Code chapter 124 excepted from the application of all or any part of that chapter may apply to the board for such exception.

a. An application for an exception under this rule shall provide evidence that an exception has been granted under the federal Controlled Substances Act.

b. The board shall permit any interested person to file written comments on or objections to the proposal for exception and shall designate the time during which such filings may be made. After consideration of the application and any comments on or objections to the proposal for exception, the board shall issue its findings on the application.

10.37(2) *Designation of new controlled substance.* The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201, subsection 4.

10.37(3) *Objection to designation of a new controlled substance.* The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an opportunity to be heard, and shall issue the board's decision on the new designation as provided in Iowa Code section 124.201, subsection 4.

657—10.38(124) Temporary designation of controlled substances.

10.38(1) Amend Iowa Code section 124.206, subsection 3, by adding the following new paragraph:

ab. Tapentadol.

10.38(2) Amend Iowa Code section 124.212, subsection 5, as follows:

5. Depressants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following substance having a depressant effect on the central nervous system, including its salts: ~~pregabalin~~

a. Lacosamide [(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide].

b. Pregabalin [(S)-3-(aminomethyl)-5-methylhexanoic acid].

10.38(3) Amend Iowa Code section 124.210, subsection 3, by adding the following new paragraph:

az. Fospropofol.

[**ARC 7906B**, IAB 7/1/09, effective 6/22/09; **ARC 8411B**, IAB 12/30/09, effective 12/1/09]

657—10.39(124,126) Excluded substances. The Iowa board of pharmacy hereby excludes from all schedules the current list of "Excluded Nonnarcotic Products" identified in Title 21, CFR Part 1308, Section 22. Copies of the list of excluded products may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

657—10.40(124,126) Anabolic steroid defined. Anabolic steroid, as defined in Iowa Code section 126.2, paragraph 2, includes any substance identified as such in Iowa Code section 124.208, paragraph 6, or in Iowa Code section 126.2, paragraph 2.

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 147.95, 147.99, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.

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CHAPTERS 38 to 99
Reserved

CHAPTER 100
IOWA REAL-TIME ELECTRONIC PSEUDOEPHEDRINE TRACKING SYSTEM

657—100.1(124) Purpose and scope. 2009 Iowa Code Supplement section 124.212B directs the governor's office of drug control policy to establish a real-time electronic repository to monitor and control the sale of Schedule V products that are not listed in another controlled substance schedule and that contain any detectible amount of pseudoephedrine, its salts, or optical isomers, or salts of optical isomers; ephedrine; or phenylpropanolamine. All pharmacies dispensing such products without a prescription shall electronically report all such sales to the repository. The real-time electronic repository shall be under the control of and administered by the governor's office of drug control policy. Both the governor's office of drug control policy and the board of pharmacy are directed to adopt rules relating to the real-time electronic repository and have jointly adopted these rules. These rules establish the pseudoephedrine tracking system (PTS).
[**ARC 8893B**, IAB 6/30/10, effective 9/1/10]

657—100.2(124) Definitions. As used in this chapter:

"Attempted purchase" means a proposed transaction for the dispensing of a product that is entered by a dispenser into the electronic pseudoephedrine tracking system, which transaction is not completed because the system recommends that the transaction be denied pursuant to the quantity limits established in 2009 Iowa Code Supplement section 124.213.

"Board" means the board of pharmacy.

"Council" means the pseudoephedrine advisory council established pursuant to Iowa Code section 124.212C.

"Dispenser" means a licensed Iowa pharmacist or a registered pharmacist-intern under the direct supervision of a pharmacist preceptor.

"Law enforcement officer" means all of the following:

1. State police officer.
2. City or county police officer.
3. Sheriff or deputy sheriff.
4. State or public university safety and security officer.
5. Department of natural resources officer.
6. Certified or full-time peace officer of this or another state.
7. Federal peace officer.
8. Criminal analyst assigned to a law enforcement agency.

"Office" means the governor's office of drug control policy.

"Product" means a Schedule V drug product that is not listed in another controlled substance schedule and that contains any detectible amount of pseudoephedrine, its salts, or optical isomers, or salts of optical isomers; ephedrine; or phenylpropanolamine.

"Pseudoephedrine tracking system" or *"PTS"* means the real-time electronic repository established to monitor and control the sale of products and administered by the governor's office of drug control policy.

"Purchaser" means an individual 18 years of age or older who purchases or attempts to purchase a product.
[**ARC 8893B**, IAB 6/30/10, effective 9/1/10]

657—100.3(124) Electronic pseudoephedrine tracking system (PTS). Unless granted an exemption by the office pursuant to these rules, all pharmacies dispensing products as defined in rule 657—100.2(124) without a prescription are required to participate in the PTS pursuant to 2009 Iowa Code Supplement section 124.212B. The office has established a council to provide input and advise the office regarding the implementation, maintenance, and administration of the PTS. The council also assists the office in developing guidelines to ensure patient confidentiality and the integrity of the relationship established by the patient and the patient's health care provider.

100.3(1) *Reporting elements.* The record of a completed purchase or attempted purchase of a product without a prescription shall contain the following:

a. The name and address of the purchaser.

b. A current government-issued photo identification number.

c. The electronic signature of the purchaser. If a pharmacy is not able to secure or record an electronic signature, a hard-copy signature logbook shall be utilized and maintained by the pharmacy. Each record in the logbook shall include the purchaser's signature and shall identify the purchase by transaction number.

d. Date and time of purchase.

e. The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.

f. The name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the product.

100.3(2) *Frequency and quantity.* Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

100.3(3) *Denial of transactions and overrides.*

a. If an individual attempts to purchase a product in violation of these rules, the PTS shall:

(1) Notify the dispenser at the time of sale; and

(2) Recommend that the dispenser deny the transaction.

b. The PTS shall provide an override feature for use by a dispenser to allow completion of the sale. For security purposes and to ensure the integrity of the PTS, use of the override feature shall be restricted to authorized dispensers and may not be delegated to a pharmacy technician or a pharmacy support person. A dispenser utilizing the override feature shall document the reason that, in the professional judgment of the dispenser, it is necessary to override the recommendation of the PTS to deny the transaction.

100.3(4) *Availability of electronic PTS.* If the electronic PTS is unavailable for use:

a. A written record of each purchase shall be maintained pursuant to 657—subrule 10.32(6).

b. The information shall be provided to the office for inclusion in the PTS within 72 hours after the PTS becomes operational.

c. A PTS administrator shall enter the information from the written record into the PTS within 72 hours of receipt.

[**ARC 8893B**, IAB 6/30/10, effective 9/1/10]

657—100.4(124) Access to database information and confidentiality. Information collected in the PTS is confidential unless otherwise ordered by a court or released by the office pursuant to state or federal law. Information may not be released except as provided by this rule.

100.4(1) *PTS administrators.* PTS administrators shall be provided access to the PTS for the purpose of searching and retrieving reports only by articulating reasonable suspicion or providing a case number or reference number for an ongoing investigation. PTS administrators shall also be provided information on purchasers directly from the PTS. This information may be sent directly to law enforcement officers pursuant to paragraph 100.4(2)*"e"* for purposes of investigation.

100.4(2) *Law enforcement release.* PTS reports may be provided to a law enforcement officer whose duty is to enforce the drug laws of this state, another state, or the United States pursuant to this subrule.

a. A law enforcement officer shall register with the PTS prior to requesting reports. To ensure the identity of the officer and to maintain confidentiality of PTS information, the officer's identity shall be verified and registration shall be approved by the office.

b. A law enforcement officer may request information or data from the PTS by providing to a PTS administrator a case or reference number for an ongoing investigation and by articulating reasonable suspicion.

c. At the discretion of the office, law enforcement officers may be given direct access to data from the PTS pursuant to the federal Combat Methamphetamine Epidemic Act.

d. If a law enforcement officer requests PTS information on purchases or attempted purchases in excess of the monthly limit established in 657—subrule 10.32(3) or subrule 100.3(2), a subpoena or other court order is required.

e. Data collected on purchases in excess of limits established pursuant to the federal Combat Methamphetamine Epidemic Act may be released to law enforcement officers by PTS administrators without a court order or articulating reasonable suspicion.

100.4(3) *Statistical data.* The PTS administrator, following establishment of confidentiality, may provide summary, statistical, or aggregate data to public or private entities for statistical, research, or educational purposes. Prior to release of any such data, the administrator shall remove any information that could be used to identify an individual patient, dispenser, or other person who is the subject of or identified in the PTS information or data.

100.4(4) *Patients.* A patient may request and receive information regarding products reported to have been purchased by the patient.

a. A patient may submit a signed, written request for records of the patient's purchases and attempted purchases during a specified period of time. The request shall identify the patient by name, including any aliases used by the patient, and shall include the patient's date of birth and gender. The request shall also include any address where the patient resided during the time period of the request and the patient's current address and daytime telephone number. A patient may personally deliver the request to the PTS administrator or authorized staff member of the office located at 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309. The patient shall be required to present current government-issued photo identification at the time of delivery of the request. A copy of the patient's identification shall be maintained in the records of the PTS.

b. A patient who is unable to personally deliver the request to the office may submit a request via mail or commercial delivery service. The request shall comply with all provisions of paragraph *"a"* above, and the signature of the requesting patient shall be witnessed and the patient's identity shall be attested to by a currently registered notary public. In addition to the notary's signature and assurance of the patient's identity, the notary shall certify a copy of the patient's current government-issued photo identification, and that certified copy shall be submitted with the written request. The request shall be submitted to the governor's office of drug control policy at the address identified in paragraph 100.4(4)*"a."*

100.4(5) *Regulatory officers.* Regulatory agencies that supervise or regulate a health care practitioner shall be able to access information from the PTS only pursuant to an order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. A director of a regulatory agency with jurisdiction over a practitioner, or the director's designee, who seeks access to PTS information for an investigation shall submit to the PTS administrator in a format established by the office a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

100.4(6) *Pharmacy administrators.* A pharmacy, an authorized employee of a pharmacy, or a licensed pharmacist shall be provided access to the stored PTS information only for the limited purpose of determining the sales made by the pharmacy. A pharmacy shall be able to print the pharmacy's sales records for any product during any specified period of time upon the request of the board or an agent of the board.

100.4(7) *Court orders and subpoenas.* The PTS administrator shall provide database information in response to a court order or a county attorney subpoena or other subpoena issued by a court upon a determination of probable cause.

[**ARC 8893B**, IAB 6/30/10, effective 9/1/10]

657—100.5(124) Violations. Violations of provisions of these rules or 2009 Iowa Code Supplement section 124.212A, 124.212B, or 124.213 may subject the violator to criminal prosecution.
[**ARC 8893B**, IAB 6/30/10, effective 9/1/10]

These rules are intended to implement 2009 Iowa Code Supplement sections 124.212, 124.212A, 124.212B, and 124.213.

[Filed ARC 8893B (Notice ARC 8666B, IAB 4/7/10), IAB 6/30/10, effective 9/1/10]

CHAPTER 4
TRAFFIC AND PARKING AT UNIVERSITIES
[Prior to 4/20/88, Regents, Board of[720]]

UNIVERSITY OF IOWA

681—4.1(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of the state University of Iowa.

681—4.2(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" means any wheeled vehicle which is not self-propelled and which is designed to be pedaled by the rider.

"Director" means the director of parking and transportation at the university or any other person designated by the president of the university to perform any function or duty of the director hereunder.

"Employee" means any person regularly employed by the university who is not a student.

"Handrail" is any railing intended to provide physical support to a pedestrian.

"Immobilization" of a bicycle consists of restricting the bicycle's use by detaining it at the point of infraction with a university locking device.

"Impoundment of a bicycle" consists of removing the owner's locking device, transporting the bicycle to a university facility, and detaining it with a university locking device.

"In-line skates" means shoes which are attached to multiple wheels for the purpose of individual transportation.

"Motorcycle" means any vehicle which is self-propelled and has less than four wheels in contact with the ground.

"Motor vehicle" means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Roller skates" means shoes which are attached to multiple wheels for the purpose of individual transportation.

"Skateboards" means any board or platform with attached wheels used for individual transportation.

"Street furniture" is any structure or accessory in a university pedestrian area or slow zone designed for the benefit of pedestrians. This includes, but is not limited to, benches, tables, lampposts, and trash receptacles.

"Student" means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

"University" means the state University of Iowa.

"Vehicle" means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" means any person who owns, operates or parks a vehicle on the university campus who is not a student or an employee.

681—4.3(262) General traffic.

4.3(1) The director shall establish such rules governing the safe operation of all vehicles, including motor vehicles, motorcycles, skateboards, in-line skates, roller skates and bicycles as the director deems necessary. Such traffic rules shall be available for inspection during business hours at the office of the director and the state board of regents. Such traffic violations may also be charged and prosecuted as violations of Iowa Code chapter 321 and Iowa Code section 262.68.

4.3(2) The director shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the state board of regents. The maps will be available for inspection during business hours at the office of the director and the state board of regents.

4.3(3) The director is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on university property.

4.3(4) The director is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes, as well as no bicycling and no skateboard, in-line skating and roller skating areas, bicycle dismount zones and pedestrian-only areas.

4.3(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.3(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for such use by the director or special permission has been granted by the director for emergency conditions.

4.3(7) Driving of vehicles, motor vehicles, and motorcycles on parts of institutional roads marked as bicycle lanes is prohibited.

4.3(8) The director is delegated authority to have the university public safety department investigate accidents which occur on university property.

681—4.4(262) Registration. Motor vehicles and motorcycles shall be registered as follows:

4.4(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student on campus must be registered with the university and a registration decal must be displayed on the vehicle in the manner prescribed by the director. Any student who operates or maintains a motor vehicle or motorcycle on campus or who owns a vehicle which is so operated or maintained is responsible for the proper registration of such vehicle and the display of the registration decal thereon.

4.4(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee is granted parking privileges on the campus. A registration decal may be issued for display on vehicles registered by employees.

4.4(3) *Procedure.* Applications for registration shall be submitted to the director in the manner the director prescribes. No student shall register any vehicle owned or actually maintained by another student. No fee shall be charged for registration without parking privileges.

4.4(4) *Bicycles.* Bicycle registration is optional.

a. To register a bicycle with the university, a current registration form is to be filled out at the parking and transportation offices. Required information includes current name of owner, address, social security number, description of the bicycle, and the bicycle manufacturer's identification number. Proof of name and address is required. Once the registration form is completed, a decal will be issued.

b. Bicycles may also be registered with the cities of Iowa City and Coralville. If these registrations are current and the decal is affixed to the bicycle, the university will accept them in lieu of a university registration.

c. Placement of registration decal. The registration process is completed when the registration decal is permanently and visibly affixed to the down- or seat-tube on the bicycle.

d. An official university bicycle registration decal is valid if the address and ownership given on the registration form are current. Change in ownership of a bicycle must be reported to the parking and transportation office. Proof of change in ownership is required.

681—4.5(262) Parking facilities. The director may set aside and designate certain areas of the university property for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The director shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.5(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.5(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.5(3) *Hours of operation.* Reasonable hours shall be established by the director for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the director.

4.5(4) *Closing.* The director may temporarily close any parking facility for cleaning, maintenance or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The director shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.5(5) *Restricted zones.* The director may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.5(6) *No parking.* Motor vehicle and motorcycle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means. No parking is permitted on grass or other vegetation or in pedestrian areas.

4.5(7) *Motorcycle parking.* The director may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.5(8) *Bicycle parking.* The director may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

4.5(9) *Violations.* Bicycles attached to, or rested against, trees, shrubs, handrails, handicapped parking meters, or limiting access to, or use of, any university facility may be impounded, the owners fined, or both. Bicycles parked inside a university building which is not designated for bicycle parking may be impounded or the owners fined, or both. Bicycles bearing proper registration decals which are attached to, or rested against, street furniture may be ticketed or immobilized and the owners fined. If the bicycles interfere with the use of the furniture, they may be impounded. Bicycles considered abandoned may be labeled for impending impoundment by placing impoundment tags on the bicycles. If the bicycles display the proper registration decals, an attempt will be made to contact the owners to remove the bicycles. If the bicycles do not display the proper registration decals, the owners have two weeks to contact the parking and transportation office from the time the bicycles are tagged until the bicycles may be impounded.

681—4.6(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such other reasonable terms and conditions as may be established by the university.

4.6(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.6(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.6(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.6(4) *Procedure.* Applications for parking privileges shall be submitted to the director in the manner the director prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The director shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.6(1), 4.6(2) and 4.6(3) and shall make all parking assignments. A parking decal or other means of identification may be issued to each applicant who is granted parking privileges, and such decal or other identification must be displayed on the vehicle in the manner prescribed by the director. Parking privileges shall not be granted to a student and to an employee for the same vehicle, and a student parking decal and an employee parking decal shall not be displayed on the same vehicle.

4.6(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.6(6) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the director.

4.6(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or to whom parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.6(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or visitor's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.6(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.7(262) Violations. Sanctions may be imposed for violation of traffic, registration and parking rules as follows:

4.7(1) *Notice of violations.* The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.7(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of university traffic, vehicle registration or parking rules. The amount of such sanctions, not to exceed $50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for traffic violations, improper registration and parking shall be published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. Traffic, registration, and parking sanctions may be

assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to the person's university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.7(3) *Impoundment and immobilization.* Any vehicle parked on the campus in violation of parking rules may be impounded, removed or immobilized. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579 and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

a. Immobilization. Immobilized bicycles bearing proper registration decals may be claimed by proving ownership and payment of immobilization fees and any fines. Immobilized bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycle under a valid name and address, and paying the appropriate fines and immobilization fees. Immobilization fees for first-time offenders may be waived after immobilized bicycles have been registered. Immobilized bicycles not reclaimed after two working days may be impounded.

b. Impoundment. Impounded bicycles bearing proper registration may be claimed by proving ownership and paying the impoundment fees and any fines. Impounded bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycles under a valid name and address, and paying the appropriate fines and impoundment fees. Impoundment fees for first-time offenders may be waived after impounded bicycles have been registered. All impounded bicycles will be held for 60 days, during which time they may be claimed by the owners upon payment of all outstanding fines and charges. After 60 days, all unclaimed impounded bicycles will be deemed abandoned property and sold pursuant to Iowa law, and the proceeds applied to the costs of impoundment, storage, and sale. The balance, if any, shall be sent to the owner, if known.

4.7(4) *Administrative hearing.* Students and employees may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate hearing body as set forth in the motor vehicle and bicycle regulations published by the university. Visitors may request the director to conduct a hearing and issue an administrative ruling in such cases.

681—4.8(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. The president may delegate presidential authority under these rules to the director or to any other person designated by the president to perform any function or duty hereunder.

681—4.9 to **4.24** Reserved.

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IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY

681—4.25(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of Iowa State University.

681—4.26(262) Definitions. For the purposes of these rules, the following definitions shall apply unless the context requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" means any vehicle having two or three wheels and fully operable pedals which is either a traditional bicycle designed solely to be pedaled by the rider or an electric bicycle designed not only to be pedaled by the rider but also propelled by an electric motor of less than 750 watts (one horsepower).

"Campus" means all property under the control of the university.

"Employee" means any person regularly employed by the university who is not a student.

"Manager" means the person(s) designated by the president of the university to perform any function or duty of the manager hereunder. At Iowa State University, that person is the director of public safety, who further delegates the duties and responsibilities to the manager of the parking division within the university's department of public safety.

"Motorcycle" or *"moped"* or *"motorized bicycle"* means any vehicle which is self-propelled and has fewer than four wheels in contact with the ground and is not a bicycle or an electric bicycle. For purposes of these rules, a moped or motorized bicycle is considered a motorcycle.

"Motor vehicle" means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Roller blades" means any frame or shoe with a single row of wheels that is used for gliding or skating. Roller blades are also known as in-line skates.

"Roller skates" means any frame or shoe with a pair of small wheels near the heel and near the toe that is used for gliding or skating.

"Skateboard" means a board with small wheels that is usually ridden by a person. For purposes of these rules, a nonmotorized scooter (a board with a handle) is considered a skateboard.

"Student" means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

"University" means Iowa State University of science and technology.

"Vehicle" means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" means any person who owns, operates or parks a vehicle on the university campus who is neither a student nor an employee.

[**ARC 8874B**, IAB 6/30/10, effective 8/4/10]

681—4.27(262) General traffic.

4.27(1) These rules shall not apply to moving traffic violations on institutional roads and property of the university. Such violations will be charged and prosecuted as violations of Iowa Code chapters 262 and 321. All state of Iowa motor vehicle laws are in effect on campus.

4.27(2) The manager shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the board of regents, state of Iowa. The maps will be available for inspection during business hours at the office of the manager and the board of regents, state of Iowa.

4.27(3) The manager is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on campus.

4.27(4) The manager is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes. All vehicle operators must obey all signs directing traffic flow on campus.

4.27(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.27(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for this use by the manager or special permission has been granted by the manager for emergency conditions.

4.27(7) Driving of vehicles, motor vehicles, and motorcycles in parts of institutional roads marked as bicycle lanes or on designated bicycle paths is prohibited.

4.27(8) Every person riding a bicycle on a street or highway on campus is granted all the privileges and is subject to all the regulations applicable to a driver of any motor vehicle on that street or highway and to the special regulations of this subrule. A bicycle rider on campus must:

a. Obey the instructions of official traffic control devices, signs and signals applicable to motor vehicles, unless otherwise directed by a peace officer or other authorized traffic director;

b. Obey the direction of any sign whenever authorized signs are erected indicating that no right, left or U-turn is permitted;

c. Obey the regulations applicable to pedestrians when the bicycle rider dismounts from the bicycle;

d. Yield the right-of-way to all vehicles approaching on a street whenever a rider is on a separate bicycle path that intersects the street;

e. Not use campus sidewalks except those specifically designated as bicycle paths;

f. Yield the right-of-way to any pedestrian in a designated crosswalk;

g. Not ride on lawns.

This subrule does not apply to peace officers of the university's department of public safety while they are acting within the scope of their regularly assigned duties.

4.27(9) Roller skates, roller blades and skateboards are permitted on campus sidewalks. Roller skates, roller blades and skateboards are not permitted on or in university structures or buildings, on stairways, sub-walks, elevated sidewalks, access ramps, steps, retaining walls, handrails or other architectural elements, on or in planting, grass or seeded areas, or where otherwise prohibited by sign, peace officer or other authorized traffic director. Any person on roller skates, roller blades or a skateboard must yield the right-of-way to any wheelchair or other mobility assistance device for the disabled, pedestrian or bicycle.

681—4.28(262) Registration. Motor vehicles, motorcycles, mopeds and bicycles shall be registered as follows:

4.28(1) *Students.* Any student who operates, maintains or owns a vehicle on university property is responsible for the proper registration of the vehicle and the display of the registration identification thereon in the manner prescribed by the manager. A student must register the vehicle within 48 hours of initial operation of the vehicle on campus.

4.28(2) *Employees.* Vehicles owned or operated by employees may be registered with the university if the employee so desires, but registration of these vehicles is not required unless the employee desires parking privileges on the campus. A registration identification shall be displayed on vehicles registered by employees in the manner prescribed by the manager.

4.28(3) *Visitors.* Vehicles owned or operated by visitors may be registered with the university if the visitor so desires, but registration of these vehicles is not required unless the visitor desires parking privileges on campus. A registration identification shall be displayed on registered vehicles by visitors in the manner prescribed by the manager.

4.28(4) *Bicycles.* Any person who rides, parks or propels a bicycle on any university property must display a bicycle identification sticker issued by Iowa State University.

4.28(5) *Procedure.* Applications for registration shall be submitted in the manner prescribed by the manager. No student shall register any vehicle owned or actually maintained by another student.

681—4.29(262) Parking facilities. The manager may set aside and designate certain areas of the campus as parking facilities for vehicles and the use of any part of the parking facilities so established may be restricted to students, employees or visitors. The manager shall cause signs to be erected

and maintained clearly identifying those areas of the campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.29(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.29(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.29(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities, and a schedule of hours of operation shall be published and available for public inspection in the office of the manager. Overnight parking is prohibited except in residence hall and vehicle storage parking facilities. Parking regulations remain in effect during semester breaks and seasonal holidays.

4.29(4) *Closing.* The manager may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The manager shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical. No parking fees will be refunded during the temporary closing of a parking facility.

4.29(5) *Restricted areas.* The manager is delegated authority to restrict access to campus streets, parking lots and other facilities by means of gates or other barriers. Streets or portions of streets may be closed to vehicle traffic or limited to specific vehicles. Access to restricted areas is limited to established gate openings or designated entrances, and no other means of access is permitted. Moving or driving around authorized barriers is prohibited.

4.29(6) *Restricted zones.* The manager may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and the restricted zones shall be conspicuously posted. No parking shall be permitted in restricted zones except as authorized.

4.29(7) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus.

a. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls.

b. No parking is permitted in prohibited zones, such as in the vicinity of fire lanes, and these zones shall be conspicuously posted or marked by painted curbs or other standard means.

c. Motor vehicles are not allowed in university buildings except:

(1) Where a shop or garage is designated as a vehicle repair or storage area;

(2) Where there is a designated vehicle loading area; or

(3) Where there is a parking ramp or deck.

d. Illegal parking is parking in any place on campus other than those areas designated for parking.

e. Improper parking is parking incorrectly in designated parking areas. Improper parking includes, but is not limited to:

(1) Parking in an area restricted by signs;

(2) Parking without an appropriate permit;

(3) Parking in an area designated for persons with disabilities;

(4) Parking in a loading zone over the time limit; and

(5) Parking over a stall marker line.

4.29(8) *Motorcycle and moped parking.* The manager may designate areas of the parking facilities for motorcycle parking, and these areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in these areas. The university may require that a parking permit be displayed on all motorcycles and mopeds.

4.29(9) *Bicycle parking.* The manager may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking. Improperly or illegally parked and abandoned bicycles may be impounded. Locking devices may be cut and removed when necessary. Bicycles may not be taken inside university buildings except as approved by the manager.

681—4.30(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon reasonable terms and conditions as may be established by the manager. An application for parking privileges may be denied if the applicant has fines for parking violations that are unpaid and past the appeal date set by these rules.

4.30(1) *Students.* Students will be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.30(2) *Employees.* Employees will be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.30(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of the time, duration or purpose of visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.30(4) *Persons with disabilities.* Persons with disabilities will be granted parking privileges in parking facilities designated for use by persons with disabilities. Persons with disabilities may apply for special parking privileges for up to six months upon issuance of a letter by the director of student health service, or the director's designee; rehabilitation counselor, student counseling service; or by a personal physician, indicating the character, extent, probable duration of the disability, and certifying the need for special parking. After an initial six months, a faculty or staff member or a student must present a currently valid department of transportation parking permit for persons with disabilities to renew the campus permit. Parking facilities designated for persons with disabilities shall be so regulated all hours of all days.

4.30(5) *Procedure.* Applications for parking privileges shall be submitted in the manner prescribed by the manager. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The manager shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.30(1), 4.30(2) and 4.30(3) and shall make parking assignments. A parking permit will be issued to each applicant who is granted parking privileges, and the permit shall be displayed on the vehicle in the manner prescribed by the manager. Parking permits are not transferable. The unauthorized possession, use, alteration, forging or counterfeiting of a parking permit, or any portion thereof, is prohibited. Parking privileges will not be granted to a student and to an employee or visitor for the same vehicle, and a student parking permit and an employee or visitor parking permit shall not be displayed on the same vehicle. Temporary parking permits may be issued to accommodate special situations. The manager shall adopt a procedure to replace lost, stolen and destroyed parking permits and controlled access entry cards.

4.30(6) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of these fees and charges shall be approved by the state board of regents. A schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the manager and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, daily, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.30(7) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the manager.

4.30(8) *Responsibility.* Any person who maintains, operates, or owns a vehicle which is on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times and for all parking violations involving the vehicle.

4.30(9) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of the facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.30(10) *Revocation.* Parking privileges on the campus may be revoked by the manager for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.31(262) Violations. Sanctions may be imposed for violation of these parking rules as follows:

4.31(1) *Notice of violations.* The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and the notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.31(2) *Sanction.* Reasonable monetary sanctions may be imposed for violation of these rules. The amount of the sanction approved by the board of regents, state of Iowa, is as follows:

Offenses	Sanctions for Each Offense
Altering, forging or counterfeiting any parking permit (4.30(5))	$150
Unauthorized possession and use of a parking permit (4.30(5))	$150
Failure to comply with signs regulating campus traffic flow (4.27(262))	$30
Driving on campus walks or lawns (4.27(6), 4.27(8))	$30
Driving on closed streets (4.27(3))	$30
Driving on bike paths (4.27(7))	$30
Access to restricted areas by means other than established gate openings (4.29(5))	$30
Moving or driving around a barricade (4.29(5))	$30
Improper use of gate card (4.29(262))	$20
Illegal parking (4.29(7))	$30
Improper parking (4.29(7))	$15
Overtime parking at meters (4.29(2))	$10
Parking without an appropriate permit in a reserved lot or space (4.29(262))	$25
Improper affixing or failure to display a permit (4.28(262))	$5
Failure to purchase a parking receipt (4.29(2))	$10
Improper parking in a space or stall designated for persons with disabilities (4.29(262), 4.30(4))	$100
Failure to display a current bicycle registration (4.28(4))	$5
Bicycle improperly parked (4.29(9))	$7.50
Improper use of roller skates, roller blades or skateboard (4.27(9))	$25
All other violations	$15

Violations that continue for more than one hour may receive additional sanctions.

Sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and may be charged to the violator's university account. Sanctions may be added to student tuition bills or

may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.31(3) *Impoundment.* Any vehicle parked on the campus in violation of these rules may be either impounded or removed, or both. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle by the university or by contract with private operators. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage, sale, and amounts due the university. The balance, if any, shall be sent to the owner.

4.31(4) *Appeal of sanction or impoundment decisions.* A person may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate university official or hearing body. A written request for a hearing and administrative ruling shall be made at the office of the university's department of public safety within ten business days of the imposition of the sanction. The manager is delegated the authority to establish a procedure, appoint an appropriate official or board, and to adopt forms and schedules to facilitate the provisions of this subrule.

4.31(5) *Judicial review.* Judicial review of an administrative ruling may be sought in an Iowa district court in accordance with the terms of the Iowa administrative procedure Act.

[**ARC 7904B**, IAB 7/1/09, effective 8/5/09]

681—4.32(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish traffic and parking procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of the duties hereunder, and any procedure so established shall be published and available for public inspection during the normal business hours in the office of the manager and the office of the board of regents, state of Iowa. The document in which such rules are published shall be known as the Department of Public Safety Parking Division Manual. The president may delegate the authority under these rules to the manager to perform any function or duty hereunder.

Rules 4.25(262) to 4.32(262) are intended to implement Iowa Code section 262.69.

681—4.33 to **4.65** Reserved.

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UNIVERSITY OF NORTHERN IOWA

681—4.66(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of parking of vehicles on the campus of the University of Northern Iowa.

681—4.67(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" is any two-wheeled vehicle which is not self-propelled and which is designed to be pedaled by the rider.

"Committee" refers to the traffic and safety committee at the university.

"Employee" is any person regularly employed by the university who is not a student.

"Motorcycle" is any vehicle which is self-propelled and has less than four wheels in contact with the ground.

"Motor vehicle" is any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Student" is any person registered with the university for academic credit or for short courses or workshops for more than a one-week period.

"Supervisor" refers to the supervisor of security at the university or to any other person or persons designated by the president of the university to perform any function or duty of the supervisor hereunder.

"University" refers to the University of Northern Iowa, located in Cedar Falls, Iowa.

"Vehicle" is any wheeled device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" is any person who owns, operates, or parks a vehicle on the university campus who is not a student or an employee.

681—4.68(262) Registration. Vehicles shall be registered as follows:

4.68(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student within Black Hawk County, Iowa, which may, at any time, use university parking facilities, must be registered with the university and a registration permit be displayed on the vehicle in the manner prescribed by the supervisor. Any student who operates or maintains a motor vehicle or motorcycle in Black Hawk County or who owns a vehicle which is so operated or maintained and which may, at any time, use university parking facilities, is responsible for the proper registration of such vehicle and the display of the registration permit thereon.

4.68(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee desires parking privileges on the campus. A registration permit may be issued for display on vehicles registered by employees.

4.68(3) *Procedure.* Applications for registration shall be submitted to the supervisor in the manner prescribed by the supervisor. No student shall register any vehicle owned or actually maintained by another student.

681—4.69(262) Parking facilities. The university may set aside and designate certain areas of the campus for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The supervisor shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.69(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.69(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.69(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the supervisor.

4.69(4) *Closing.* The supervisor may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility

as may be necessary or convenient. The supervisor shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.69(5) *Restricted zones.* The supervisor and committee may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.69(6) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means.

4.69(7) *Motorcycle parking.* The supervisor and committee may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.69(8) *Bicycle parking.* The supervisor and committee may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

681—4.70(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such reasonable terms and conditions as may be established by the university.

4.70(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.70(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.70(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.70(4) *Procedure.* Applications for parking privileges shall be submitted to the supervisor in the manner the supervisor prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The supervisor shall determine the eligibility and priority of each applicant for parking privileges and shall make all parking assignments. A parking permit or other means of identification may be issued to each applicant who is granted parking privileges, and such permit or other identification must be displayed on the vehicle in the manner prescribed by the supervisor.

4.70(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries

or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.70(6) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by supervisor and committee.

4.70(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.70(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of the university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.70(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.71(262) Violations. Sanctions may be imposed for violation of registration and parking rules as follows:

4.71(1) *Notice of violations.* The university shall give written notice of all parking or registration violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.71(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of vehicle registration or parking rules. The amount of such sanctions, not to exceed $50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for improper registration and parking shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. Registration and parking sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to their university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.71(3) *Impoundment.* Any vehicle parked on the campus in violation of parking or registration rules may be impounded and removed. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold, under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

4.71(4) *Hearing.* Students and employees may have a hearing on any registration or parking violation. A hearing request shall be submitted to the supervisor in writing within seven days after notice of the violation was given and shall state the grounds of the hearing request. The supervisor may allow additional time within which to request a hearing for good cause shown. Hearings shall be conducted by an impartial committee to be chosen in a manner approved by the president of the university. The person requesting said hearing shall be afforded the opportunity for an administrative hearing by the hearing committee and shall be given reasonable notice of the time and place of the hearing. The decision of the hearing committee shall be final and may be reviewed *de novo* by the district court as provided by law.

681—4.72(262) Effect of rules. These rules constitute a condition of registration as a student at the university and a condition of employment as an employee of the university. Registration as a student or acceptance of employment constitutes an acceptance of these rules and an agreement to pay all prescribed fees and monetary fines imposed in accordance with these rules.

681—4.73(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. The president may delegate presidential authority under these rules to the supervisor or to any other person designated by the president to perform any function or duty hereunder.

These rules are intended to implement Iowa Code chapter 262.

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For history of traffic and parking for each university, see history at end of each division of this chapter.

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[Prior to 11/19/97, see Labor Services Division[347]]

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PROFESSIONAL BOXING

[Prior to 9/24/86, Athletics Commissioner[110] Ch 2]
[Prior to 10/21/98, see 347—Ch 97]
[Prior to 8/16/06, see 875—Ch 97]

875—173.1(90A) Limitation of rounds. Ten rounds shall be the maximum number of rounds for a boxing bout, except for a championship match which may not exceed 15 rounds. Three minutes of boxing will constitute a round, or by special permission of the commissioner, two minutes. There shall be a rest period of one minute between rounds.

875—173.2(90A) Weight restrictions. Permission must be received from the commissioner before a contestant will be permitted to box an opponent 18 pounds heavier than the boxer in the welterweight or middleweight classes, or 6 pounds heavier than the boxer in or under the lightweight class.

875—173.3(90A) Age restrictions. No contestant under the age of 18 years shall be permitted to participate in any event except by special permission of the commissioner. If permission is granted, a boxer under the age of 18 years shall not be permitted to box more than four rounds. No contestant under the age of 21 shall be permitted to box more than six rounds until the boxer has participated in ten or more professional bouts. However, if in the judgment of the commissioner the boxer has had sufficient experience, the boxer may be allowed to participate in bouts of longer duration.

875—173.4(90A) Injury. If a contestant claims to be injured during the bout, the referee shall stop the bout and request the attending physician to make an examination. If the physician decides that the contestant has been injured as the result of a foul, the physician shall advise the referee of the injury. If the physician is of the opinion that the injured contestant may be able to continue, the physician shall order a five-minute intermission, after which the physician shall make another examination and again advise the referee of the injured contestant's condition. It shall be the duty of the promoter to have an approved physician in attendance during the entire duration of all bouts.

875—173.5(90A) Knockdown. If a contestant falls due to fatigue or is knocked down by the opponent, the contestant shall be allowed ten seconds in which to rise unassisted. When a contestant falls, the opponent shall go to the farthest neutral corner and remain there during the ten-second count. The referee shall stop counting should the opponent fail to go to a neutral corner.

875—173.6(90A) Limitation on number of bouts. Any boxing contestant who has agreed to take part in a bout of five rounds or more shall not be permitted to participate in any other bout in Iowa or elsewhere five days prior to the date of the bout unless given permission by the commissioner.

875—173.7(90A) Contestants' arrival. All main event contestants shall be in the city or locale at least 24 hours before the scheduled time of the bout or contest. The promoter shall advise the commissioner of the arrival time. Any exception to this rule shall be approved by the commissioner.

875—173.8(90A) Persons allowed in the ring. No person other than the contestants and the referee shall enter the ring during the bout, excepting the seconds between the rounds or the attending physician if asked by the referee to examine an injury to a contestant.

875—173.9(90A) Protection of hands. Only one roll of cotton gauze surgical bandage, not to exceed 2 inches in width and 10 yards in length, shall be used for the protection of each hand. Only one winding of surgeons' adhesive tape not more than 1½ inches in width may be placed directly on the hand to protect that part of the hand near the wrist. Said tape may cross the back of the hand twice, but shall not extend within 1 inch of the knuckles when the hand is clenched to make a fist.

875—173.10(90A) Scoring. Twenty points shall be the maximum number to be scored in any round. The contestant winning the round shall receive ten points and the opponent proportionately less. If the round is even, each contestant shall receive ten points.

875—173.11(90A) Gloves. The gloves must not be twisted or manipulated in any way by the contestants or their handlers. If a glove breaks or a string becomes untied during the bout, the referee will instruct the timekeeper to take time out while the glove is being adjusted.

875—173.12(90A) Proper attire. Contestants must wear proper athletic attire. Athletic attire of opposing contestants shall be of contrasting colors. Male contestants shall wear a foul proof protective cup. Female contestants shall wear foul proof pelvic area protection and breast protection.

875—173.13(90A) Use of substances. Excessive use of cocoa butter, petroleum jelly, grease, ointments or strong-smelling liniment by a contestant during the progress of a bout will not be permitted.

875—173.14(90A) "Down." A boxer will be deemed down when:

1. Any part of the boxer's body other than the boxer's feet is on the ring floor or while rising from a down position.
2. The boxer is hanging helplessly over the ring ropes, but then is not officially down until so pronounced by the referee, who may count the boxer out either on the ropes or on the floor.

875—173.15(90A) Foul. The following activities will be deemed a foul:

1. Hitting below the belt or after the bell has terminated the round.
2. Hitting an opponent who is down or who is getting up after being down.
3. Holding an opponent or deliberately maintaining a clinch.
4. Holding an opponent with one hand and hitting with the other hand.
5. Butting with head or shoulders or using the knee.
6. Hitting with inside or butt of the hand, the wrist or the elbow and all backhand blows.
7. Hitting or "flicking" with the open glove or thumbing.
8. Wrestling or roughing at the ropes.
9. Purposely going down without being hit.
10. Striking deliberately at that part of the body over the kidneys.
11. Use of the pivot blow or rabbit punch.
12. Use of abusive or profane language.
13. Failure to obey the referee, or any physical actions which may injure a contestant, except by fair sportsmanlike boxing.

875—173.16(90A) Penalties. The referee will penalize a contestant guilty of committing any foul by deducting points from the contestant's score for the round in which the foul is committed. If, in the referee's judgment, the foul is of a serious nature or intentionally inflicted, the referee may award the bout to the contestant who was fouled.

875—173.17(90A) Weight classes. Scale of weights:

	[Pounds]
Flyweight	112
Bantamweight	118
Featherweight	126
Lightweight	135
Welterweight	147
Middleweight	160
Light heavyweight	175
Heavyweight	Over 175

875—173.18(90A) Attendance of commissioner. At each boxing card, the commissioner or the commissioner's designee shall be in attendance.

875—173.19(90A) Weighing of contestants. Contestants shall be weighed and examined on the day of the scheduled match by the attending ring physician, at a time and place to be determined by the commissioner. Preliminary boxers may be allowed to weigh in and be examined not later than one hour before the scheduled time of the first match on the card. All weigh-ins will be conducted with the boxer stripped. Accurate scales shall be furnished by the promoter.

875—173.20(90A) Officials. Officials will consist of the referee, physician, timekeeper and three judges. These officials and the contestants, seconds and managers are subject to approval by the commissioner.

875—173.21(90A) General requirements. The commissioner shall not approve bout permits for bouts on Christmas Day. "Battles royal" or bouts in which more than two boxing contestants are to appear in the ring at the same time shall not be approved. In programs where both amateur and professional contestants appear on the same card, there shall be no more than four amateur bouts of three rounds each. The amateur contests shall be under the complete control and supervision of the United States of America Amateur Boxing Federation authority. On each card containing amateur and professional contests, there shall be at least an equal or greater number of bouts of professional boxing. The amateur section of the card shall be held first with at least a 15-minute intermission between the amateur and professional events.

875—173.22(90A) Public safety. Promoters are held responsible to ensure that adequate public safety is maintained at all bouts. At least one law enforcement officer, furnished by the promoter, must be in attendance with additional law enforcement officers as required by the need to maintain adequate public safety. Failure to provide may result in the cancellation of the matches and the revocation of the promoters' licenses.

875—173.23(90A) Excessive coaching. Excessive coaching and other detracting activities by seconds, managers or trainers while the bouts are in progress are prohibited. Offenders will be warned and if the violation continues, the offending contestant may be charged with a foul and a loss of points.

875—173.24(90A) Abusive language. The use of foul or abusive language or mannerisms by any person associated with any bout shall not be tolerated.

875—173.25(90A) Locker rooms. Admission to locker rooms shall be restricted to the commissioner or designee, officials, contestants, their managers and seconds. Locker rooms shall be kept neat and clean.

875—173.26(90A) Contracts. All contracts between promoters and contestants shall be written on official forms furnished by the commissioner. One copy of each contract shall be filed with the commissioner at least seven days prior to the date of the bout, unless a specific individual delay is

approved by the commissioner. Telegrams or letters indicating acceptance of terms will be considered an agreement between a contestant, the contestant's manager and the promoter pending the actual signing of the contract.

875—173.27(90A) Ring requirements. The ring shall not be less than 16 nor more than 22 feet square within the ropes and must be elevated 3½ feet above the floor. Suitable steps for the use of contestants shall be provided.

875—173.28(90A) Ring posts. The ring posts shall be constructed of metal not more than 4 inches in diameter. The posts shall extend from the floor of the building to the height of 58 inches above the ring floor and shall be fastened securely to the floor or to the other posts.

875—173.29(90A) Ropes. The ropes shall be a minimum of three in number, extending in a triple line 18 inches, 35 inches and 52 inches from the floor of the ring; at least 1 inch in diameter; and wrapped in soft materials. The ropes may not be closer to the ring posts than 18 inches. If four ropes are used, they will be proportionately spaced.

875—173.30(90A) Ring floor. The ring floor shall extend beyond the lower rope for a distance of not less than 18 inches. The entire floor shall be padded to the thickness of at least 1 inch with felt, corrugated paper, matting or other soft materials to be approved by the commissioner. A canvas covering stretched tightly and laced to the ring platform shall cover the padding.

875—173.31(90A) Bell. A suitable bell or gong shall be provided and used.

875—173.32(90A) Gloves. Gloves shall not weigh less than 8 ounces for professional bouts and must be new for all main events and bouts of ten rounds or greater. All gloves shall be furnished by the promoter.

875—173.33(90A) Referee's duties. The referee is charged with the enforcement of all rules of the commissioner which apply to the performance and conduct of contestants and their seconds while in the ring.

875—173.34(90A) Chief second. Before starting each bout the referee shall ascertain the name of the chief second in each corner and will hold the chief second responsible for all conduct in the corner.

875—173.35(90A) Naming referee. The promoters shall be permitted to name a referee subject to approval by the commissioner.

875—173.36(90A) Reasons for stopping bout. The referee shall stop a bout when the referee deems it advisable because of the physical condition of one or both of the contestants, when one of the contestants is clearly outclassed by an opponent, when the referee decides that the best effort is not being made by a contestant, or for any other reason the referee deems sufficient.

875—173.37(90A) Forfeit of purse. The referee has the power to declare forfeited all or any part of a contestant's purse whenever in the referee's judgment the contestant is not performing in good faith.

875—173.38(90A) Inspection for foreign substances. The referee shall inspect the gloves, bandages, and bodies of the contestants in all main events and make sure that no foreign substances have been applied to the gloves, bandages, or bodies of the contestants that might be detrimental to an opponent. In bouts preliminary to the main event when the gloves are adjusted in the dressing rooms, the referee shall inspect the gloves and bodies of the contestants.

875—173.39(90A) Shaking hands. The contestants in all boxing bouts shall be instructed by the referee to shake hands after the referee's final instructions and not to do so again until the start of the last scheduled round.

875—173.40(90A) Assessing fouls. The referee shall instruct the judges to mark their scorecards accordingly when the referee has assessed a foul and deduct a point from one of the contestants.

875—173.41(90A) Delaying prohibited. The referee shall ensure that a bout move to its proper completion. Except in cases of damaging fouls, a bout shall not be delayed. Delaying and avoiding tactics shall be avoided and the contestant who employs such tactics shall be penalized in the scoring.

875—173.42(90A) Count. When a fallen contestant rises and falls again, without being hit again, the referee shall continue the original count rather than starting a new count.

875—173.43(90A) Intentional foul. In assessing fouls, the referee shall weigh the cause as well as the act. When a foul is unintentionally inflicted but intentionally received, it should be applied to the recipient who deliberately receives the foul.

875—173.44(90A) Use of the ropes. The referee shall penalize a contestant who uses the ropes to gain advantage. The penalty shall be the deduction of points, and a warning to the contestant against continued use of the ropes to gain advantage.

875—173.45(90A) Attending ring physician. When a boxer has been injured seriously, knocked out or technically knocked out, the referee shall immediately summon the attending ring physician to aid the stricken boxer. Managers, handlers and seconds shall not attend to the stricken boxer, except at the request of the physician.

875—173.46(90A) Technical knockout. Except for championship fights of national recognition, the referee shall stop the fight after a fighter is knocked down three times in one round and declare the opponent a winner on a technical knockout (TKO).

875—173.47(90A) Timekeeper. The timekeeper shall provide a stopwatch and shall maintain an accurate time of all bouts. The timekeeper shall keep an exact record of time taken out at the request of a referee for an examination of a contestant by the physician, replacing a glove or adjusting any equipment during a round. The timekeeper shall provide a whistle and shall sound the whistle ten seconds before the start of each round of boxing bouts. The timekeeper shall be impartial and shall not signal interested parties at any time during a bout.

875—173.48(90A) Seconds. Unless special permission is given by the commissioner, there shall not be more than two seconds. Before the start of the bout, each corner shall notify the referee the name of the chief second.

875—173.49(90A) Requirements for seconds. Seconds shall not enter the ring until the timekeeper indicates the termination of the round and they must leave at the sound of the timekeeper's whistle before the beginning of each round. If the chief second or anyone for whom the promoter is responsible, such as a manager, enters the ring before the bell ending the round has sounded, the fight shall be terminated and the decision shall be awarded to the opponent. Seconds shall not smoke in the ring or corners and shall not wear a hat or cap while working in the corner.

875—173.50(90A) Use of water. Seconds shall not throw or splash water upon a contestant. A wet sponge may be used between rounds to refresh the contestant. Excess water on the floor of the ring shall be wiped up immediately by the seconds. Water discharged from the mouth of a contestant shall be caught in a bucket.

875—173.51(90A) Stopping the fight. The throwing of a towel into the ring to indicate the defeat of a contestant shall not be recognized by the referee. The fight will be stopped when the second or manager appears on the ring apron.

875—173.52(90A) Removing objects from ring. Before leaving the ring at the start of each round the seconds shall remove all obstructions, buckets, stools, bottles, towels and robes from the ring floor and ropes.

875—173.53(90A) Decision. Each judge shall reach a decision without conferring in any manner with any other official or person. Each judge shall make out a scorecard to the best of the judge's ability and in accordance with the provisions of the rules governing boxing. At the end of the bout the decision shall be written on the scorecard and the card shall be given to the commissioner or designee for verification who shall then hand the cards to the referee who will then announce the decision. The winner shall be determined on the majority vote of the three judges and each judge shall select a choice based on the highest number of points.

875—173.54(90A) Blood-borne disease testing. At least one week before each event, the promoter shall submit to the labor commissioner and to the ringside physician test results showing that each contestant scheduled for the event tested negative for the human immunodeficiency, hepatitis B, and hepatitis C viruses within the six-month period prior to the event. The contestant shall not participate and the physician shall notify the promoter that the contestant is prohibited from participating for medical reasons if any of the following occurs:

1. The promoter does not produce timely proof of testing;
2. The test results are positive;
3. The laboratory is not properly certified in accordance with the federal Clinical Laboratory Improvement Act;
4. The test was performed more than six months prior to the event; or
5. The test results are otherwise deficient.

875—173.55(90A) Boxer registration. The commissioner participates in the Association of Boxing Commissions (ABC) national boxer registration system which allows authorities from different states to share information concerning boxers. The issuance of a registration card to a boxer does not guarantee the right to participate in a match.

173.55(1) *Application.* A boxer shall apply for registration in the state where the boxer resides, unless the state where the boxer resides does not participate in the ABC registration system. A person applying for a new or renewal boxer registration shall complete, sign, and submit to the division the ABC Boxer's Federal Identification Card Application. With the application, the applicant shall submit a $25 fee; two 1″ × 1.5″ color photographs of the applicant's head; and a copy of a photo identification issued to the applicant by a governmental entity and containing the applicant's photograph and social security number or similar foreign identification number. The applicant must be recognizable in the photographs.

173.55(2) *Expiration.* The registration shall expire two years from the date of issuance.

173.55(3) *Changes.* The boxer shall notify the division at the time any of the information on the form changes.

173.55(4) *Denials.* The labor commissioner may refuse to issue or renew a boxer registration for failure to complete an application package properly.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

These rules are intended to implement Iowa Code chapter 90A.

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NOTE: For first two lines of history, see Athletics Commissioner[110] Ch 2.

CHAPTER 177
MIXED MARTIAL ARTS

[Prior to 10/21/98, see 347—Ch 101]
[Prior to 8/16/06, see 875—Ch 101]

875—177.1(90A) Definitions. The definitions contained in Iowa Code chapter 90A as amended by 2010 Iowa Acts, Senate File 2286, and the definitions in this rule shall apply to this chapter.

"Contestant" means a person who fights or is scheduled to fight in a match.

"Event" means a program or card of one or more matches covered by Iowa Code chapter 90A.

"Match" means a mixed martial arts match.

"Mixed martial arts" means a style of athletic contest that includes a combination of combative skills from the sports of boxing, wrestling, kickboxing and judo.

"MMA" means mixed martial arts.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.2(90A) Responsibilities of promoter.

177.2(1) *License.* Rescinded IAB 6/30/10, effective 8/4/10.

177.2(2) *General.* The promoter shall:

a. Ensure compliance with the rules of this chapter;

b. Ensure that the referees are familiar with and enforce the rules;

c. Be responsible for the conduct of all officials and participants;

d. Answer to the commissioner for noncompliance; and

e. Be available to the commissioner throughout an event or identify a designee who shall be:

(1) Available to the commissioner throughout an event; and

(2) Authorized by the promoter to address issues that may arise.

177.2(3) *Contracts.* A promoter shall enter into a written contract with each contestant using the form furnished by the commissioner. Telegrams, fax transmissions, electronic mail, or letters indicating acceptance of terms will be considered an agreement between a contestant, the contestant's manager and the promoter pending the actual signing of the contract.

177.2(4) *Event officials provided.* The promoter shall provide all officials and ensure their attendance during the entire event. The officials are subject to approval by the commissioner.

177.2(5) *Protective equipment and gloves provided.* The promoter shall provide all equipment, personal protective equipment and gloves.

177.2(6) *Public safety.* The promoter shall ensure that adequate public safety is maintained at all events. At least one law enforcement officer, who is certified pursuant to Iowa Code chapter 80B, and adequate personnel provided by a private security company shall be furnished by the promoter. When the commissioner finds that failure to provide adequate security to maintain public safety imperatively requires emergency action, the commissioner may immediately suspend the event license, pending license revocation procedures pursuant to Iowa Code chapter 17A.

177.2(7) *Prohibited events.* No promoter shall arrange or advertise:

a. A match between persons of the opposite sex;

b. A match in which more than two contestants are to appear in the cage at the same time;

c. A match with a contestant who is younger than 18 years of age; or

d. A match between a contestant who has previously fought in a reported professional MMA match and a contestant who has not previously fought in a reported professional MMA match. Prior to applying for a license pursuant to subrule 177.2(9), a promoter shall confirm that each contestant on an amateur card has not participated in a reported professional MMA match by visiting www.mixedmartialarts.com.

177.2(8) *Advance notice of event.* A promoter shall submit advance notice of an event to the commissioner on the form provided by the commissioner at least 30 days prior to the event. The advance notice shall include:

a. The date, time, and location of the event;

b. The date, time, and location for weighing the contestants;

c. The promoter's name and contact information;

d. The name, contact information, and role of each proposed official; and

e. Other relevant information requested by the commissioner on the form.

177.2(9) *License.* A promoter shall not hold an event prior to the promoter's obtaining a license. At least seven days before the event, the promoter shall submit an application for a license on the form provided by the commissioner. The promoter shall submit with the application each of the following:

a. A bond in the sum of $5,000, payable to the State of Iowa, conditioned upon the payment of the tax and penalties imposed by Iowa Code chapter 90A as amended by 2010 Iowa Acts, Senate File 2286, unless the promoter has a current valid bond on file with the division;

b. The name, address, weight, gender, and opponent of each contestant;

c. A copy of the medical license of the ringside physician;

d. Copies of the contracts with the contestants, the emergency medical services company, and the security company;

e. The name and contact information for the certified law enforcement officer that will attend the event;

f. The date, time, and location of the ringside physician's examination of the contestants;

g. The date, time, and location for weighing the contestants;

h. Certificates of health and life insurance as required by rule 875—177.10(90A);

i. Proof of age for each contestant that shall consist of a copy of one of the following documents:

(1) A certified birth certificate;

(2) A passport;

(3) A certified baptismal record;

(4) A U.S. visa;

(5) An identification card issued to the contestant by a governmental entity and which includes the contestant's photograph and birth date; or

(6) A U.S. resident alien card.

j. Other relevant information requested by the commissioner on the form.

177.2(10) *Emergency medical service.* A promoter shall ensure that an ambulance service authorized at the EMT-B, EMT-I, EMT-P or paramedic specialist level pursuant to 641—Chapter 132 is present at the event. A promoter is fully responsible for all charges assessed by the ambulance service related to the event except:

a. Charges covered by insurance.

b. Charges for services provided to persons other than participants and officials.

177.2(11) *Cleaning.* The promoter shall provide and maintain a container with a solution of ten parts water to one part bleach to clean bodily fluids from any part of the cage, cage enclosure, or floor.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.3(90A) Equipment specifications.

177.3(1) *Ring requirements.*

a. *Size.* The cage shall not be less than 16 nor more than 36 feet square.

b. *Enclosure.* The ring shall be equipped with an enclosure to limit persons from being tossed from the ring. The enclosure shall be at least 6 feet high. The enclosure shall consist of supports and enclosing material. The supports shall be constructed of rigid material not more than 4 inches in diameter. The supports shall be fastened securely to the floor or to the other supports. The supports shall be protected by padding to avoid injury to any contestants striking the supports. The enclosing material shall have openings not to exceed 4 inches in any direction. The enclosing material shall not be rigid and shall deflect at least ½ inch when ten pounds of pressure are exerted upon any point. All sharp objects or protrusions shall be protected with padding.

c. *Height.* The ring shall not be elevated more than 3½ feet above the floor. Suitable steps for the use of contestants shall be provided.

d. *Ring floor.* The ring floor shall be padded to the thickness of at least 1 inch with insulite or other soft materials to be approved by the commissioner. A canvas covering stretched tightly and laced to the ring platform shall cover the padding.

e. *Ring approval.* The promoter shall make the ring and ring enclosure system available in the state of Iowa for inspection by the commissioner at least ten days prior to any event. The specifications in this rule are general, and so actual inspection will be necessary to verify adequate contestant safety prior to the event. If the commissioner has previously inspected the ring used by the promoter, the commissioner may waive the ten-day advance inspection.

177.3(2) *Bell.* A suitable bell or gong shall be provided and used.

177.3(3) *Time keeping.* The timekeeper shall be provided with a stopwatch and whistle.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.4(90A) Event.

177.4(1) *Officials.* Officials shall consist of three judges, two referees, the physician, and the timekeeper.

177.4(2) *Referee.* The referee is charged with the enforcement of all rules of the commissioner which apply to the performance and conduct of contestants and their seconds while in the ring. The referee shall wear latex gloves at all times while in the ring.

177.4(3) *Timekeeper.* The timekeeper shall keep an exact record of time taken out at the request of a referee for an examination of a contestant by the physician, replacing a glove or adjusting any equipment during a round. The timekeeper shall notify contestants at the beginning and end of each round. The timekeeper shall be impartial and shall not signal interested parties at any time during a match.

177.4(4) *Participants.* The contestants, seconds and managers are subject to approval by the commissioner.

177.4(5) *Weighing of contestants.* Rescinded IAB 6/30/10, effective 8/4/10.

177.4(6) *Scoring.* Three judges shall score each match by evaluating striking, grappling, control of the cage, aggressiveness, and defense. The significance and number of legal strikes shall receive the greatest weight. The number of legal takedowns and reversals shall receive the second greatest weight. Control of the cage shall receive the third greatest weight. Aggression shall receive the fourth greatest weight. Defense shall receive the least weight. The winner of a round shall always receive a score of 10. The score for each round shall be one of the following:

a. If the contestants were evenly matched and neither dominated the round, the score shall be 10-10.

b. If a contestant won a round by a close margin, the score shall be 10-9.

c. If a contestant overwhelmingly dominated a round, the score shall be 10-8.

d. If a contestant totally dominated a round, the score shall be 10-7.

177.4(7) *Length of match.* Each match shall consist of no more than three rounds with no more than five minutes per round. However, the commissioner may authorize experienced contestants to compete in up to five rounds of up to five minutes each. There shall be a one-minute rest period between rounds. An overtime round shall not be allowed.

177.4(8) *Persons allowed in the cage.* No person other than the two contestants and the referee shall enter the cage during the match. However, the physician may enter the cage to examine a contestant upon the request of the referee.

177.4(9) *Seconds.*

a. Unless special permission is granted by the commissioner, there shall be no more than two seconds. Before the start of the match, each corner shall notify the referee of the name of the chief second.

b. Seconds shall not enter the cage except as authorized by this paragraph. The chief second may enter the cage after the timekeeper indicates the termination of the round, and the chief second must leave before the beginning of a round.

c. Before leaving the ring at the start of the round, the seconds shall remove all obstructions, buckets, stools, bottles, towels and robes from the ring floor and ring enclosure.

d. Seconds shall not smoke in the ring or corners and shall not wear a hat or cap while working in the corner.

e. Seconds shall wear latex gloves at all times while attending any contestant.

f. Seconds shall not throw or splash water upon a contestant. Excess water on the floor of the cage shall be wiped up immediately. Water discharged from the mouth of a contestant shall be caught in a bucket.

177.4(10) *Decorum of officials and participants.*

a. Except as allowed in this subrule, a promoter, official, or participant shall not:

(1) Intentionally or recklessly strike or injure a person;

(2) Speak or act in a threatening manner toward a person; or

(3) Damage, destroy, or attempt to damage or destroy property.

b. The commissioner may immediately suspend the promoter's license if the promoter does not comply with paragraph 177.4(10)*"a"* or if the promoter does not take appropriate action to curtail activities in violation of paragraph 177.4(10)*"a"* by an official or a participant.

c. The commissioner may immediately suspend the authorization to participate in the event of an official or a participant who does not comply with paragraph 177.4(10)*"a."*

d. A contestant is exempt from 177.4(10)(a)(1) and (2) while interacting with the contestant's opponent during a round. However, if the round is stopped by the physician or referee for a time out, 177.4(10)(a)(1) and (2) shall apply to a contestant.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.5(90A) Contestants.

177.5(1) *Time between matches.* No contestant shall be permitted to compete if the contestant participated in a boxing, wrestling, kickboxing, judo, or mixed martial arts event within the previous five-day period.

177.5(2) *Age restrictions.* No contestant under the age of 18 years shall be permitted to participate in any event except by special permission of the commissioner.

177.5(3) *Proper attire.* Contestants must wear proper athletic attire. Athletic attire of opposing contestants shall be of contrasting colors.

177.5(4) *Body protection.* All male contestants shall wear a foulproof protective cup. All female contestants shall wear foulproof pelvic area protection and breast protection.

177.5(5) *Mouth protection.* Each contestant shall wear a mouthpiece throughout each match. If the mouthpiece is knocked from a contestant's mouth, it shall be washed and then replaced.

177.5(6) *Gloves.* Gloves shall be approved martial arts gloves. All gloves shall be approved by the commissioner.

177.5(7) *Hand protection.* Only one roll of cotton gauze surgical bandage, not to exceed 2 inches in width and 10 yards in length, shall be used for the protection of each hand. Only one winding of surgeons' adhesive tape, not more than 1½ inches in width, may be placed directly on the hand to protect that part of the hand near the wrist. The tape may cross the back of the hand twice, but shall not extend within 1 inch of the knuckles when the hand is clenched to make a fist. Practice wraps (training handwraps) may be used in lieu of gauze and tape.

177.5(8) *Hair protection.* Where necessary, hair shall be secured in a manner that it will not interfere with the vision or safety of either contestant.

177.5(9) *Use of substances.* A contestant shall not use any substance including, but not limited to, cocoa butter, petroleum jelly, grease, ointments or strong-smelling substances without permission of the referee.

177.5(10) *Contestants' grooming.* Fingernails will be trimmed closely.

177.5(11) *Blood-borne disease testing.* At least one week before each event, the promoter shall submit to the labor commissioner and to the ringside physician test results showing that each contestant scheduled for the event tested negative for the human immunodeficiency, hepatitis B, and hepatitis C viruses within the six-month period prior to the event. The contestant shall not participate and the physician shall notify the promoter that the contestant is prohibited from participating for medical reasons if any of the following occurs:

a. The promoter does not produce timely proof of testing;

b. The test results are positive;

c. The laboratory is not properly certified in accordance with the federal Clinical Laboratory Improvement Act;

d. The test was performed more than six months prior to the event; or

e. The test results are otherwise deficient.

177.5(12) *Weighing contestants.*

a. The promoter shall arrange for each contestant to be weighed in Iowa during the 24-hour period prior to the event.

b. Accurate scales shall be furnished by the promoter.

c. An official who has been approved by the commissioner shall weigh each contestant and accurately record the contestant's name and weight and the date and time. The weight records shall be submitted to the commissioner on the date of the event.

d. All contestants scheduled for an event shall be weighed on the same date.

e. Contestants shall be weighed in the presence of their opponents and without shoes, clothes or equipment.

f. Unless both contestants weigh more than 200 pounds, there shall not be a weight difference of more than 20 pounds between opponents without the commissioner's consent.

g. No less than two weeks before the event, a promoter may request that a representative of the commissioner be present when contestants are weighed. The fee for this optional service shall be $200 plus reasonable and necessary travel expenses.

177.5(13) *Examination of contestants.* On the day of the event, at a time and place to be approved by the commissioner, the ringside physician shall conduct a rigorous physical examination to determine the contestant's fitness to participate in an MMA match. A contestant deemed not fit by the physician shall not participate in the event.

[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.6(90A) Procedural rules.

177.6(1) *Inspection for foreign substances.* The referee shall inspect the gloves, bandages, and bodies of the contestants and make sure that no foreign substances have been applied to the gloves, bandages, or bodies of the contestants that might be detrimental to an opponent.

177.6(2) *Prohibited materials in ring.* Contestants shall not take anything not permitted by these rules into the ring or pick up anything thrown into the ring and use the material or object in any way to gain an advantage over an opponent.

177.6(3) *Fouls.* As set forth in this subrule, the referee may penalize a contestant for fouls by disqualifying the contestant or by deducting points. The referee shall immediately determine if each foul is flagrant or accidental. "Flagrant" means the foul was intentional or reckless. "Accidental" means the foul was unintentional or incidental.

a. *Disqualification.* If the referee determines that the foul was flagrant and the contestant who was fouled is unable to continue due to an injury resulting from the foul, the contestant who committed the foul shall be disqualified.

b. *Deduction of points.* In determining the number of points to be deducted, the referee shall consider the nature and severity of the foul and its effect upon the opponent. As soon as practical after the foul, the referee shall notify the judges, contestants, and the commissioner of the number of points, if any, to be deducted from the score of the offender and whether the foul was flagrant or accidental. Points shall be deducted in the round in which the foul occurred.

c. *Continuation of match.* This paragraph governs how a match shall be continued if a foul that does not result in disqualification occurs.

(1) If a foul occurred but did not cause a serious injury, the referee may order the match to continue after a five-minute delay for recuperation. If subsequent fair blows aggravate the injury inflicted by a foul and the referee orders the contest stopped because of the injury, the outcome will be determined by scoring the completed rounds and the round during which the referee stopped the match.

(2) If an accidental foul results in a concussive impact to the head, if a contestant's chance of winning has been seriously jeopardized as a result of an accidental foul, or if a contestant is not able to

continue the match due to an injury caused by an accidental foul, "no contest" will be declared or the winner will be determined based on points as set forth below.

1. "No contest" will be declared if:

- The foul occurs during the first two rounds of a match scheduled for three rounds or fewer.
- The foul occurs during the first three rounds of a match scheduled for four or five rounds.

2. The winner will be determined by scoring the completed rounds and the round during which the referee stopped the match if:

- The foul occurs during the third round of a match scheduled for three rounds.
- The foul occurs during the fourth or fifth round of a match scheduled for four or five rounds.

d. *Prohibited acts.* Each of the following actions is a foul:

(1) Butting with the head.
(2) Eye gouging of any kind.
(3) Biting.
(4) Hair pulling.
(5) Fishhooking.
(6) Groin attacks of any kind.
(7) Putting a finger into any orifice, cut, or laceration on an opponent.
(8) Small joint manipulation.
(9) Striking to the spine or behind the ears.
(10) Striking using the point of the elbow.
(11) Throat strikes of any kind, including, without limitation, grabbing the trachea.
(12) Clawing, pinching or twisting the flesh.
(13) Grabbing the clavicle.
(14) Kicking the head of a grounded opponent.
(15) Kneeing the head of a grounded opponent.
(16) Stomping a grounded opponent.
(17) Striking the kidney.
(18) Dropping or slamming an opponent on an opponent's head or neck.
(19) Throwing an opponent out of the cage or fenced area.
(20) Holding the shorts or gloves of an opponent.
(21) Spitting at an opponent.
(22) Engaging in any unsportsmanlike conduct that causes an injury to an opponent.
(23) Holding the ropes or the fence.
(24) Using abusive language in the cage or fenced area.
(25) Attacking an opponent during a break.
(26) Attacking an opponent who is under the care of the referee.
(27) Attacking an opponent after the bell has sounded the end of the round.
(28) Flagrantly disregarding the instructions of the referee.
(29) Timidity, including, without limitation, avoiding contact with an opponent, intentionally or consistently dropping the mouthpiece or faking an injury.
(30) Interference by a second.
(31) Throwing in the towel during competition.
(32) Threatening or intentionally striking or injuring any person other than the contestant's opponent.

177.6(4) *Mouth protection ejected.* If the mouth protection is knocked from a contestant's mouth, it shall be replaced with no penalty.

177.6(5) *Spitting mouth protection.* The referee shall caution a contestant who deliberately spits out a mouthpiece the first time and disqualify the contestant the second time.

177.6(6) *Gloves.* The gloves shall not be damaged or manipulated in any way by the contestants or their handlers. If a glove breaks or becomes undone during a match, the referee will instruct the timekeeper to take time out while the glove is being adjusted or replaced.

177.6(7) *Injury.* If a contestant claims to be injured or when a contestant has been injured seriously or knocked out, the referee shall immediately stop the fight and summon the attending ring physician to

make an examination of the stricken fighter. If the physician decides that the contestant has been injured, the physician shall advise the referee of the severity of the injury. If the physician is of the opinion the injured contestant may be able to continue, the physician shall order a five-minute intermission, after which the physician shall make another examination and again advise the referee of the injured contestant's condition. Managers, handlers and seconds shall not attend to the stricken fighter, except at the request of the physician.
[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.7(90A) Decision. A professional match concludes when:

177.7(1) A contestant submits.

177.7(2) The timekeeper indicates that time has expired in the final round of the match. The win will be awarded based on the judges' scores.

177.7(3) The referee stops the match.

177.7(4) The referee disqualifies a contestant for committing a foul pursuant to rule 875—177.6(90A).

177.7(5) A second or manager throws a towel into the cage to indicate the defeat of a contestant. The referee shall stop the match and award the win to the opponent.

177.7(6) A second or manager is in the cage when prohibited. The referee shall stop the match and award the win to the opponent.
[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

875—177.8(90A) Forfeit of purse. The commissioner, in consultation with the referee, has the power to declare forfeited all or any part of a contestant's purse whenever in the commissioner's judgment the contestant was not performing in good faith.

875—177.9(90A) Attendance of commissioner. Rescinded IAB 8/1/07, effective 9/5/07.

875—177.10(90A) Health and life insurance.

177.10(1) Each promoter shall obtain $25,000 of health insurance coverage on each fighter to provide for medical, surgical and hospital care for injuries sustained and illnesses contracted during the event. If the fighter pays for covered care, the insurance proceeds shall be paid to the fighter or the fighter's beneficiaries as reimbursement for payment. The deductible, if any, shall be the sole responsibility of the promoter and shall not be charged to or paid by the fighter.

177.10(2) Each promoter shall provide no less than $20,000 of life insurance coverage on each fighter to cover death caused by injuries sustained or illnesses contracted during the event.

177.10(3) The promoter shall provide a certificate of health and life insurance to the labor commissioner at least one week before an event. Failure to provide timely proof of insurance that is acceptable to the labor commissioner shall be grounds to deny the issuance of a license for the event.

177.10(4) Insurance policies shall be purchased from companies authorized to do business in the state of Iowa.
[**ARC 8916B**, IAB 6/30/10, effective 8/4/10]

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◊ Two or more ARCs

SAILBOATS
See BOATS AND BOATING

SALE BARNS
See LIVESTOCK: Movement: Markets

SALES AND USE TAX
See TAXATION

SALONS
See COSMETOLOGY AND COSMETOLOGISTS

SALVAGE
See also FOOD; GAME; MOTOR VEHICLES
Landfills, salvaging **567**—113.8(1)*c*

SANATORIUMS
Mentally ill, *see MENTAL HEALTH*
Oakdale **681**—12.1(3)
Tuberculosis **681**—12.1(3)

SAND
See MINES AND MINING: Minerals
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